

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MEDICAL CERTIFICATION**

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 00191 CERTIFICATE OF DEATH 00193

00193

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b>		c. LENGTH OF STAY IN 1b <b>1 year 6 months</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>College Park, Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b>		d. STREET ADDRESS <b>1020 Nantuxet Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Gladys</b>		First <b>M</b>		Middle <b>A</b>	
Last <b>Aulerson</b>		4. DATE OF DEATH <b>1</b>		Month <b>6</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-9-94</b>		9. AGE (in years last birthday) <b>72</b>		10. IF UNDER 1 YEAR (Months) Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>FRANK CROSMAN</b>		14. MOTHER'S MAIDEN NAME <b>HELENE SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>578-54-0631</b>		17. INFORMANT <b>Records, Mount Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis Far advanced</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>18 months</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <b>5-26-1965</b> to <b>1-6-1967</b> , that (I) (we) last saw the deceased alive on <b>1-6-1967</b> , and that death occurred at <b>HP</b> M, from the causes and on the date stated above.		22a. SIGNATURE <b>Wm. Newcomer</b>	
22b. DATE SIGNED <b>Jan 6-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b>		22d. ADDRESS <b>Mount Wilson, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Jan. 9-1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Addison Chapel</b>	
23d. LOCATION (City, town or county) (State) <b>Seat Pleasant, Maryland.</b>		24. FUNERAL DIRECTOR <b>Simmons Bros</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00192

CERTIFICATE OF DEATH

00192

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>38 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>				d. STREET ADDRESS <b>2811 E. BIDDLE STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>BENNIE</b> Middle <b>--</b> Last <b>BAILEY</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>9</b> Year <b>19 67</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 28, 1902</b>	
9. AGE (In years last birthday) yrs. <b>64</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCIER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ISLE OF WRIGHT, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>BEN BAILEY</b>			
14. MOTHER'S MAIDEN NAME <b>MITTIE DAVIS</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>			
16. SOCIAL SECURITY NO. <b>220 07 31 97</b>				17. INFORMANT <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>ADENOCARCINOMA OF PROSTATE WITH METASTASIS TO BONE MARROW</b> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (a) DUE TO (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>12/2/66</b> , 19__ to <b>1/9/67</b> , 19__, that (we) lost saw the deceased alive on <b>1/9/67</b> , 19__, and that death occurred <b>12:48 AM</b> from causes and on the date stated above.							
22a. SIGNATURE <i>Jorge A. Fabara</i>				22b. DATE SIGNED <b>1/9/67</b>		22c. PHYSICIAN'S NAME (Type) <b>JORGE A. FABARA, M. D.</b>	
22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>				22e. REC'D BY REGISTRAR <b>10 1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>1-12-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>		23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>MORTEN &amp; DYETT FUNERAL HOME</b>				25. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00193

CERTIFICATE OF DEATH

00195

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Baltimore</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Randallstown</b>	
c. LENGTH OF STAY IN 1b <b>22 days</b>		d. STREET ADDRESS <b>3722 Offutt Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Ridgeway Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frances Virginia Baker</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>3</b> Year <b>19 67</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/27/1871</b>
9. AGE (In years lost birthday) yrs. <b>95</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Chestertown, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Milton E. Baker</b>	
14. MOTHER'S MAIDEN NAME <b>Emeline Frazier</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>214-54-4241 T</b>		17. INFORMANT Address <b>Randallstown</b> <b>Mrs. Kathryne Rankin-3722 Offutt Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>cardio vascular disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>small</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>18 Dec</b> , 19 <b>66</b> , to <b>3 Jan</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>3 Jan</b> 19 <b>67</b> and that death occurred at <b>home</b> from causes and on the date stated above			
22a. SIGNATURE <b>William Goodman, MD</b>		22b. DATE SIGNED <b>4 Jan 67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Wm. Goodman</b>		22d. ADDRESS <b>1334 Sulphur Spring Rd. 21227</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>1/5/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Chester Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>
24. FUNERAL DIRECTOR <b>Loring Byers-8728 Liberty Rd. Randallstown, Md</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 6 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00196

00194

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>14 Arrowship Road</b>		d. STREET ADDRESS <b>14 Arrowship</b>	
3. NAME OF DECEASED (Type or print) <b>Anna Rebecca Baldwin</b>		4. DATE OF DEATH <b>January 3 1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1888</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Albert Rose</b>		14. MOTHER'S MAIDEN NAME <b>Annie Rose</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If lives give year or dates of service)	
17. INFORMANT <b>George W. Baldwin</b>		Address <b>14 Arrowship Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Colman Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension + A-S-C-V-Disease</b> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>MB Davis</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Melvin B. Davis, M. D.</b>		DATE SIGNED <b>Jan. 3, 1967</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/6/67</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Louden Park Cemetery</b>	22d. LOCATION (City, town, or country) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR <b>Ullrich Funeral Home, Dundalk, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 5 1967</b>	
		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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528 J. B. A. Jansen et al.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00195

00197

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |  |  |  |  |
|--|--|--|---|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>   |  |  |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY _____<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>2818 W. Cold Spring Lane</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>IDA</u> Middle _____ Last <u>Bard</u>   |  | <b>4. DATE OF DEATH</b><br>Month <u>January</u> Day <u>15</u> Year <u>1967</u>   |   | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u>   |  |  |  |
| <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>75</u> yrs.  |  | <b>9. AGE</b> (In years last birthday) <u>75</u> yrs.<br>IF UNDER 1 YEAR Months _____ Days _____   |   | IF UNDER 24 HRS. Hours _____ Min. _____  |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>At Home</u>  |   | <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>USA</u>  |  |  |  |
| <b>13. FATHER'S NAME</b> <u>Jacob Caplan</u>   |  |  | <b>14. MOTHER'S MAIGN NAME</b> <u>Anna Tucker</u> |  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b> <u>220-05-1222A</u>   |   | <b>17. INFORMANT</b> <u>Mr. Albert C. Bard</u> Address <u>1323 Fidelity Building</u> #1  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>(b) <u>arteriosclerotic Heart Disease</u><br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>5 years</u> |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>   |  |  |   |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| <b>20f. (City or town)</b> _____ (County) _____ (State) _____  |  | <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 22, 1965</u> <b>to</b> <u>Jan 15, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan. 15, 1967</u> <b>and that death occurred at</b> <u>12:15 PM</u> <b>from the causes and on the date stated above.</b> |   |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Manuel Levin</u>  |  |  |   | <b>22b. DATE SIGNED</b> <u>1/15/67</u>   |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type) <u>MANUEL LEVIN, M.D.</u>  |  | <b>22d. ADDRESS</b> <u>4818 REISTERSTOWN RD BALTIMORE MD</u>   |   |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>   |  | <b>23b. DATE THEREOF</b> <u>1/16/67</u>  |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore Hebrew</u>  |  |  |  |
| <b>23d. LOCATION</b> (City, town or county) <u>Baltimore, Maryland</u> (State) _____   |  | <b>24. FUNERAL DIRECTOR</b> <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown</u>  |   |  |  |  |  |
| <b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>  |  | <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>   |   |  |  |  |  |
| <b>DATE</b> <u>JAN 20 1967</u>   |  |  |   |  |  |  |  |

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FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00196

00198

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Retain along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                                    | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)<br>a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>                |  |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>ARBUTUS</b>   |                                    | c LENGTH OF STAY IN 1b<br><b>3 WEEKS</b>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>5516 DOLORES Ave + 27</b>  |                                    | e STREET ADDRESS<br><b>1722 WILKENS Ave + 23</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ANNA MARGARET BARNETTE</b>   |                                    | 4 DATE OF DEATH<br>Month Day Year<br><b>JANUARY 21 1967</b>   |  |
| 5 SEX<br><b>F</b>  | 6 COLOR OR RACE<br><b>W</b>        | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8 DATE OF BIRTH<br><b>5/8/1915</b>   |
| 9 AGE (In years) <b>51</b><br>Months Days Hours Min  |                                    | 10a USUAL OCCUPATION (Give kind of work done during most of work life even if retired)<br><b>SUPERVISOR</b>   |  |
| 10b KIND OF BUSINESS OR INDUSTRY<br><b>MONTG. WARD</b>   |                                    | 11 BIRTHPLACE (State or foreign country)<br><b>BALTIMORE</b>  |  |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    | 13 FATHER'S NAME<br><b>PETER LUX</b>  |  |
| 14 MOTHER'S MARDEN NAME<br><b>MARGARET HOFMAN</b>  |                                    | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NA</b>                                     |  |
| 16 SOCIAL SECURITY NO<br><b>215-09-1427</b>  |                                    | 17 INFORMANT<br><b>MRS. M. LUX-MOTHER, ARBUTUS, MD.</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>CANCER OF THE ABDOMEN</b><br><b>171.1</b> DUE TO <b>BIRTH METASTASIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>(c) _____   |                                    |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>                          |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____  |                                    |   |  |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                    | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  | 20e PLACE OF INJURY (Home, farm, factory, street, office, etc.)            |
| 20f (City or town) (County) (State)  |                                    |   |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                    |   |  |
| ACTUAL SIGNATURE <b>Edmund Kasaitis M.D.</b>   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>EDMUND KASAITIS M.D.</b>   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|  |                                    | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |
|  |                                    | Address (Street, city, town, or county)   |  |
| 22. DATE SIGNED<br><b>1/21/67</b>  |                                    |   |  |
| 23a BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>1/24/67</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>London Park Cemetery Baltimore, Maryland</b>  | 23d LOCATION (City or town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Amber, Inc. 1528 Sulphur Spring Rd.</b>   |                                    | 25a REC'D BY REGISTRAR<br><b>J. Charles Judge</b>   |  |
| 25b REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                    | DATE <b>JAN 23 1967</b>   |  |



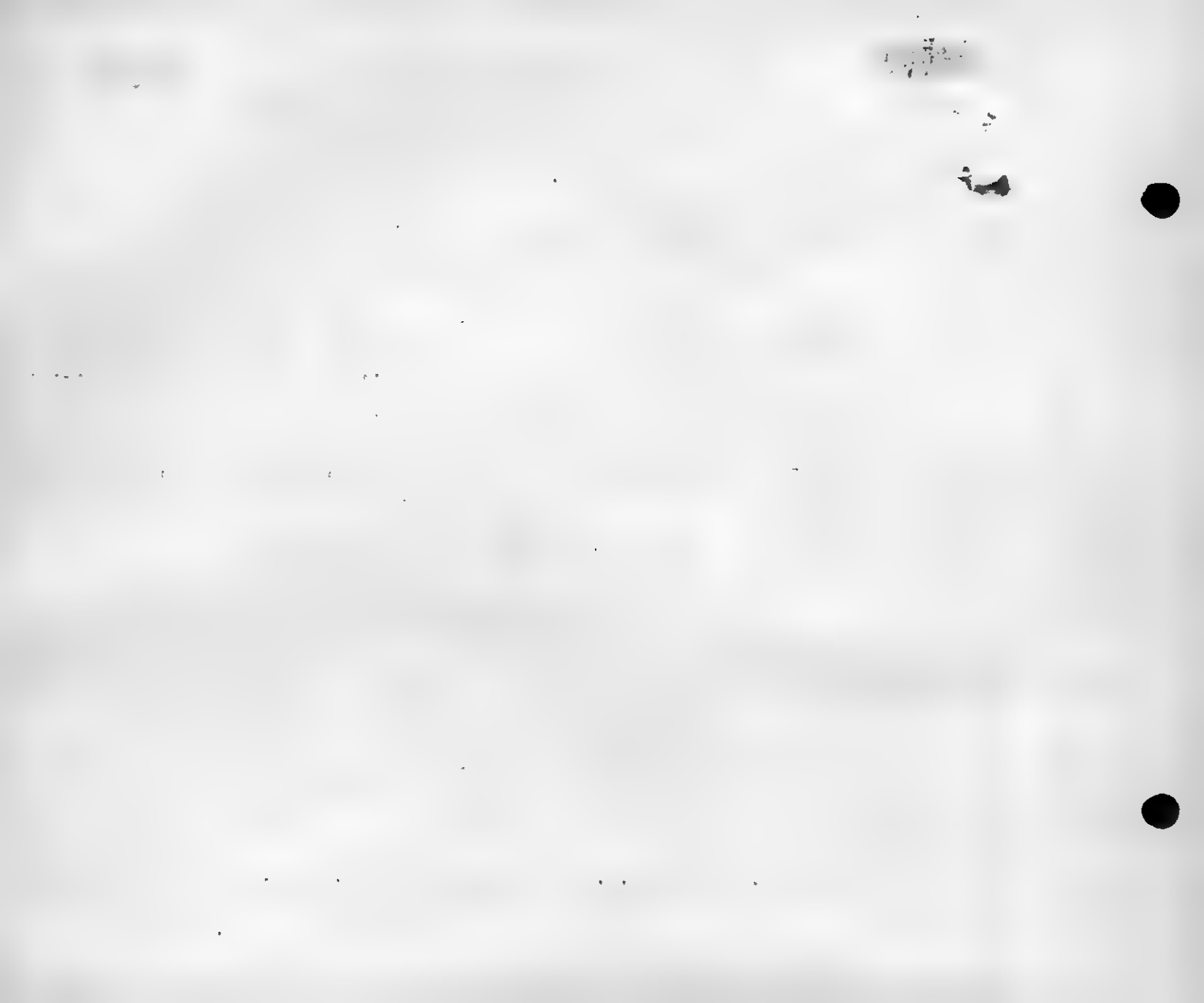
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |   |  |  |   |  |  |                                  |  |  |
|--|--|---|---|---|---|---|--|--|---|--|--|----------------------------------|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |   |   |   |   |   |  |  |   |  |  |                                  |  |  |
| 00197  |  |   |   |   | CERTIFICATE OF DEATH  |   |  |  |   | 00199  |  |                                  |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |   |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Kent</b> ✓ |   |  |  |   |  |  |                                  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>13 yrs.</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rock Hall</b>                                    |   |  |  |   |  |  |                                  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>   |  |   |   |   | d. STREET ADDRESS<br><b>Hawthorne Road</b>  |   |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |                                  |  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>Samuel</b> Middle <b>Jay</b> Last <b>BATCHELOR</b>   |  |   |   |   | 4 DATE OF DEATH<br>Month <b>1</b> Day <b>13</b> Year <b>19 67</b>   |   |  |  |   |  |  |                                  |  |  |
| 5 SEX<br><b>Male</b>   |  | 6 COLOR OR RACE<br><b>White</b>   |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | B. DATE OF BIRTH<br><b>10-24-47</b>   |  | 9. AGE (In years last birthday)<br><b>19</b> yrs |   | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  | 1. IF UNDER 24 HRS<br>Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>  |  |   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Kent Co., Maryland</b> |  |  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |                                  |  |  |
| 13. FATHER'S NAME<br><b>William Herbert Batchelor</b>  |  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Helen Frances Elbourn</b>  |   |  |  |   |  |  |                                  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  |   | 16. SOCIAL SECURITY NO<br><b>none</b>     |   | 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>  |   |  |  |   | Address  |  |                                  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO <b>MENTAL RETARDATION (EPILEPSY)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>MENTAL RETARDATION (EPILEPSY)</b><br>DUE TO<br>(c) |  |   |   |   |   |   |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b>                                  |  |                                  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>CIRRHOSIS</b>   |  |   |   |   |   |   |  |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |   |  |  |   |  |  |                                  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |  |   |  |  |                                  |  |  |
| 21. I certify that (this hospital) attended the deceased from <b>10-20</b> , 19 <b>53</b> , to <b>1-13</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>1-13</b> , 19 <b>67</b> , and that death occurred at <b>8:30am</b> , from causes and on the date stated above.   |  |   |   |   |   |   |  |  |   |  |  |                                  |  |  |
| 22a. SIGNATURE<br><b>Harry G. Butler</b> M.D.  |  |   |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |   | 22b. DATE SIGNED<br><b>1-13-67</b>                 |  |   |  |  |                                  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Harry G. Butler, M.D.</b>   |  |   |   |   | 22d. ADDRESS<br><b>Rosewood St. Hosp., Owings Mills, Md.</b>  |   |  |  |   |  |  |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>JAN. 14</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Wesley CHAPEL</b>  |   | 23d. LOCATION (City or town) (County) (State)<br><b>Rock Hall MD.</b>           |  |  |   |  |  |                                  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Edgar L. Lane Church Hill Md.</b>   |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 17 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |   |  |  |                                  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

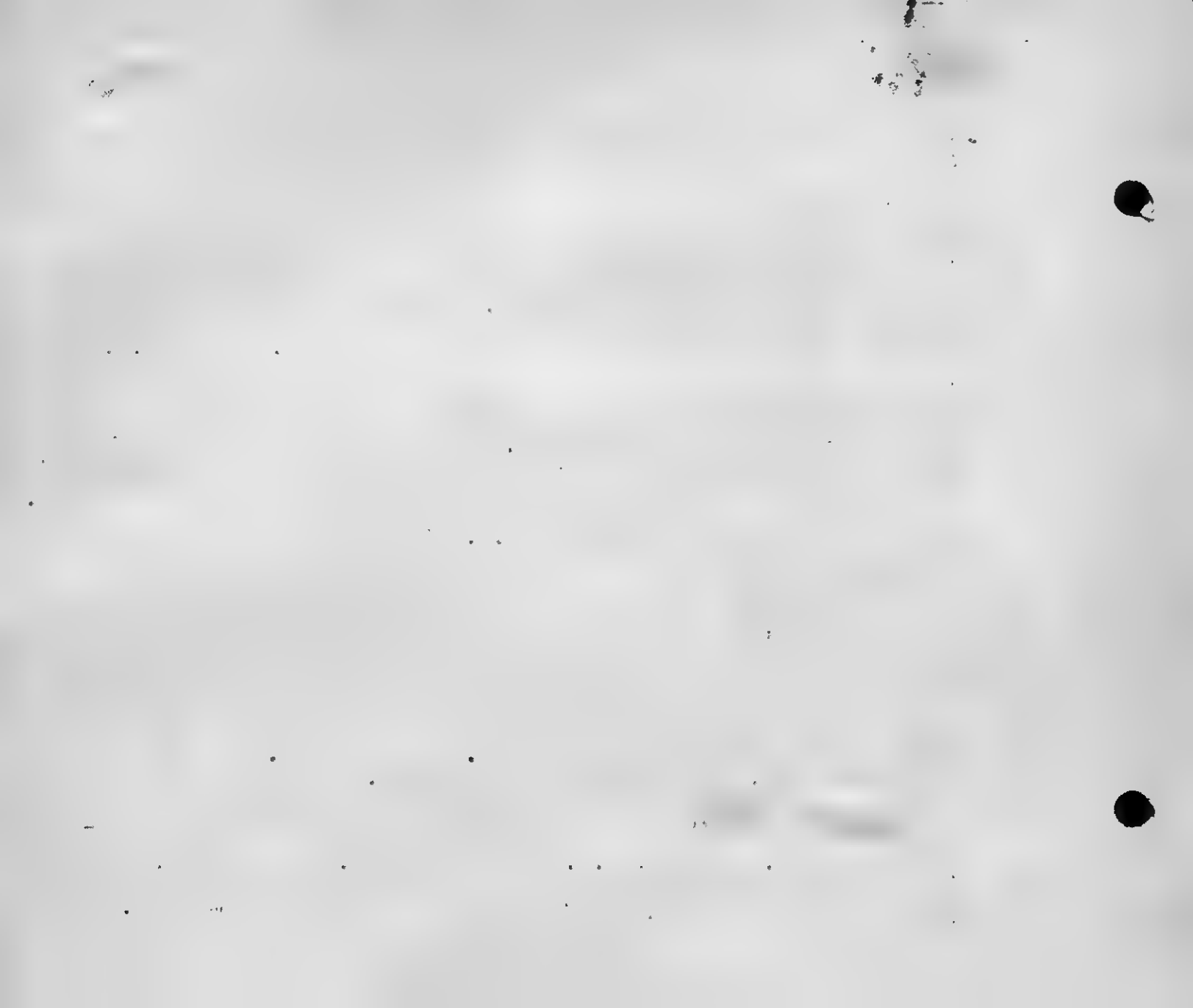
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15M 7-62

00498

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00200

|  |                                  |  |   |
|--|----------------------------------|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY<br>Baltimore<br>MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Reisterstown<br>c. LENGTH OF STAY IN IT<br>65 years<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>16 Bond Avenue  |                                  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Baltimore<br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>Reisterstown<br>d. STREET ADDRESS<br>16 Bond Avenue<br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print)<br>First Middle Last<br>Flavilla Harrison Battle   |                                  | <b>4. DATE OF DEATH</b><br>Month Day Year<br>January 22, 1967  |   |
| <b>5. SEX</b><br>Female  | <b>6. COLOR OR RACE</b><br>Negro | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b><br>Jan. 5, 1902<br>9. AGE (In years last birthday) 65<br>IF UNDER 1 YEAR Months Days<br>IF UNDER 24 HRS. Hours Min. |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br>Domestic   |                                  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br>Housework  |   |
| <b>11. BIRTHPLACE</b> (County & State or foreign country)<br>Reisterstown, Md.   |                                  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br>U.S.A.  |   |
| <b>13. FATHER'S NAME</b><br>Louis Harrison   |                                  | <b>14. MOTHER'S MAIDEN NAME</b><br>Elsie Waters  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br>No  |                                  | <b>16. SOCIAL SECURITY NO.</b><br>212-32-1840  |   |
| <b>17. INFORMANT</b><br>Mr. Charles Battle   |                                  | Address<br>16 Bond Ave.<br>Reisterstown, Md.   |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)<br>7X41 DUE TO Pulmonary Edema<br>Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic C.V. Disease<br>(a), stating the underlying cause last. DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>Ulcerative Colitis<br>INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.<br>years |                                  |  |   |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |   |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |                                  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |                                  | <b>20f. (City or town)</b> (County) (State)  |   |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> Sept. 9, 1952 <b>to</b> Jan. 22, 1967, <b>that (I) (we) last saw the deceased alive on</b> Jan. 19, 1967 <b>and that death occurred at</b> 10 AM <b>from the causes and on the date stated above.</b>   |                                  |  |   |
| <b>22a. SIGNATURE</b><br>Martin E. Strobel<br>M D  |                                  | <b>22b. DATE SIGNED</b><br>1-23-67   |   |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br>Martin E. Strobel, M.D.   |                                  | <b>22d. ADDRESS</b><br>48 Main St. Reisterstown, Maryland  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br>Burial   |                                  | <b>23b. DATE THEREOF</b><br>1/25/67  |   |
| <b>23c. NAME OF CEMETERY OR CREMATORY</b><br>St. Luke's Cemetery   |                                  | <b>23d. LOCATION</b> (City, town or county) (State)<br>Reisterstown, Md.   |   |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br>N J Schhardt  |                                  | <b>25a. REC'D BY REGISTRAR</b><br>Owings Mills, Md.<br>DATE JAN 24 1967  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br>Charles Judge   |                                  |  |   |





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00139

CERTIFICATE OF DEATH

00201

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |   | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>143 Oaklee Village</b>  |   | d. STREET ADDRESS<br><b>143 Oaklee Village</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>LOUIS F. BATZER</b>  |   | 4. DATE OF DEATH<br><b>January 6, 1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3-4-1891</b>   |
| 9. AGE (In years last birthday)<br><b>75</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work ing life, even if retired)<br><b>Retired Pipefitter</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>John Batzer</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W W I</b>  |   | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>Mr. Bernard C. Batzer, 603 Ralston Ave.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Hypertensive-arterio-sclerotic C.V.D.</b><br>44'51<br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ |   |   | INTERVA. BETWEEN ONSET AND DEATH<br><b>15 years</b>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>OCT. 9, 1948</b> to <b>Jan 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 31, 1966</b> , and that death occurred at <b>8 A M.</b> from causes on and on the date stated above  |   |   |   |
| 22a. SIGNATURE<br><b>Kennard Yaffe</b>   |   | 22b. DATE SIGNED<br><b>1/8/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Kennard Yaffe</b>   |   | 22d. ADDRESS<br><b>5501 Forest Park Ave. Balto., Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-9-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore County, Maryland</b>                |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 10 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00200

## CERTIFICATE OF DEATH

00202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |   |  |   |  |
|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |   |  |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN Id   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21234</b>                                   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |                                  |   | d. STREET ADDRESS<br><b>2897 Willoughby Road</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>H.</b> Last <b>Beck</b>  |                                  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>21</b> Year <b>19 67</b>  |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-1-<del>18</del> 95.</b>  | 9. AGE (In years last birthday)<br><b>71</b> yrs                        | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Cont. Can Co.</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  |
| 12. CIT. ZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Henry L. Beck</b>  |                                  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sophia Hoffman</b>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>216-05-1726</b>  |  | 17. INFORMANT<br><b>Mrs. Naomi Riggleman</b> Address <b>(Same)</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Chronic Myelogenous Leukemia</b>  |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
|  |                                  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <b>Jan. 14, 1967</b> to <b>Jan. 21, 1967</b> , that (1) (we) last saw the deceased alive on <b>Jan. 21, 1967</b> , and that death occurred at <b>12:05 PM</b> , from causes and on the date stated above.                              |                                  |   |  |   |  |
| 22a. SIGNATURE<br><i>Elmo M. Gayoso</i>  |                                  |   | M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>          |   | 22b. DATE SIGNED<br><b>Jan/ 21, 1967</b>   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Elmo M. Gayoso</b>  |                                  |   | 22d. ADDRESS<br><b>7620 York Road- Towson 21204, Md.</b>   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/24/67.</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cemetery</b> |  |
|  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |  |   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |                                  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |



00201

## CERTIFICATE OF DEATH

00203

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Overlea</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Overlea Dial</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>2 Glenmore Avenue #36</u>   |  | d. STREET ADDRESS<br><u>2 Glenmore Avenue #36</u>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>David O Becker</u>   |  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>6</u> Year <u>1967</u>  |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>12-27-1930</u>   |
| 9. AGE (In years lost birthday)<br><u>36</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>   |   |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Gas Electric Co.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>Edmund Becker</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Jane Masley</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO.<br><u>212-05-3215</u>   |   |
| 17. INFORMANT<br><u>Mrs Edith Walters</u>  |  | Address<br><u>7515 Kenlea Avenue 36</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary occlusion</u><br>DUE TO <u>Coronary occlusion</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u>Coronary occlusion</u><br>DUE TO <u>Coronary occlusion</u><br>(c) <u>Coronary occlusion</u> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 minutes</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Coronary occlusion, blood clot</u>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10 Feb</u> , 19 <u>65</u> , to <u>4 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4 Jan 1967</u> , and that death occurred at <u>7A</u> M, from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><u>Howard Goodman</u>  |  | 22b. DATE SIGNED<br><u>6 Jan 67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Howard Goodman</u>  |  | 22d. ADDRESS<br><u>4601 Kilmorland Rd.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>1-9-1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore, Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home 7401 Belair Road</u>   |  | 25. REC'D BY REGISTRAR<br>DATE <u>JAN 9 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





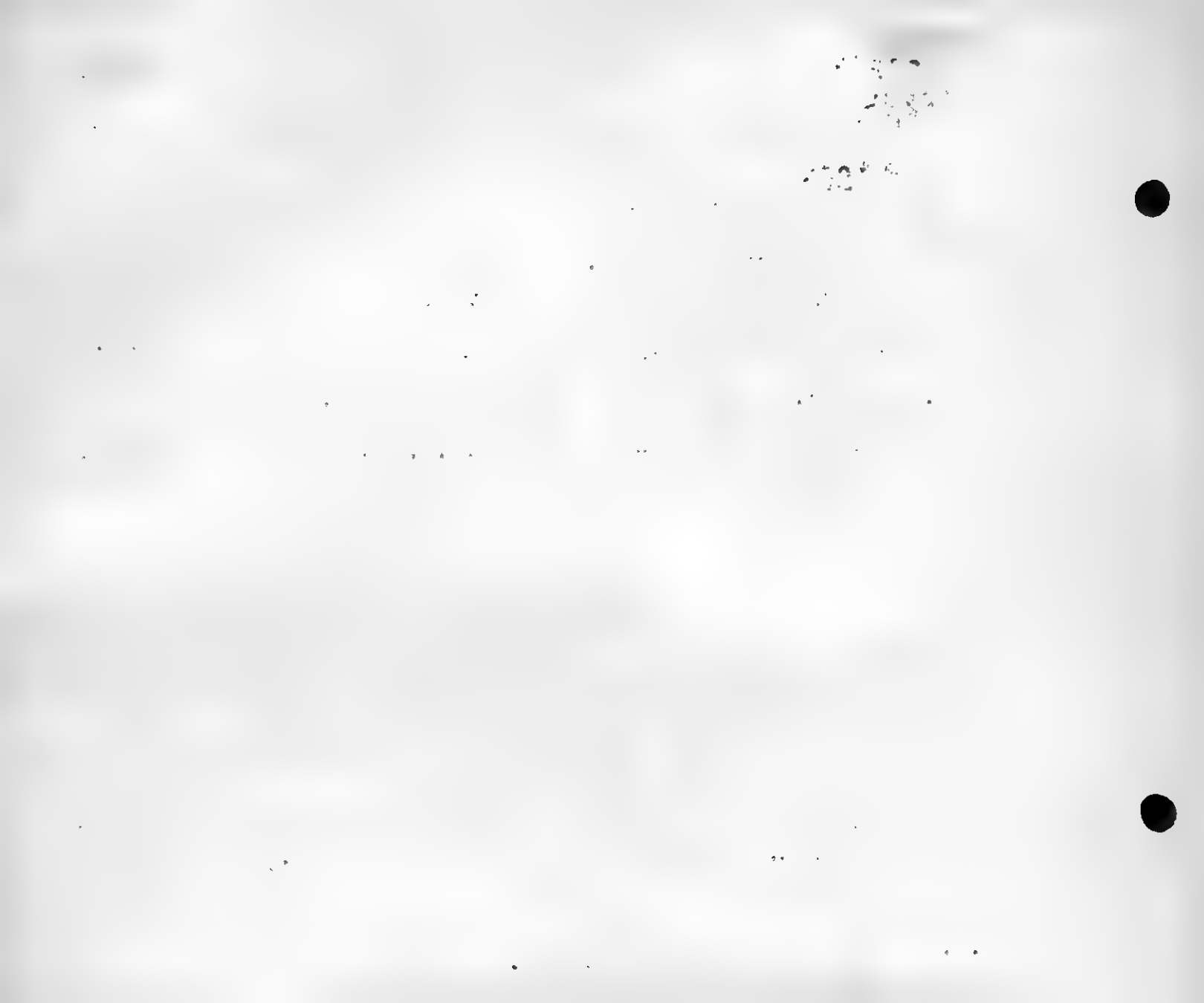
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |  |  |  |  |  |  |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|--|--|--|--|
| CERTIFICATE OF DEATH   |  |                                  |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |                                  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>   |  |                                  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7712 Greenview Terrace</b>   |  |                                  |  |  |  | d. STREET ADDRESS <b>7712 Greenview Terrace</b>  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last <b>Bruce H. Beeler Jr.</b>   |  |                                  |  |  |  | 4. DATE OF DEATH Month Day Year <b>1 9 1967</b>  |  |  |  |  |  |
| 5. SEX <b>M</b>  |  | 6. COLOR OR RACE <b>W</b>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>6-13-1918</b>  |  | 9. AGE (In years last birthday) <b>48 yrs.</b> |  | IF UNDER 1 YEAR Months Days Hours Min.           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Gilman School</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Delaware</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>        |  |  |  |
| 13. FATHER'S NAME <b>Dr. Bruce H. Beeler</b>   |  |                                  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Eleanor R. Graves</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>   |  |                                  |  | 16. SOCIAL SECURITY NO. <b>WW 11</b>   |  | 17. INFORMANT <b>Mrs. F.G. Headley</b>   |  | Address <b>Westfield, N.J.</b>                 |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)           |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9/5</b> , 19 <b>63</b> , to <b>January</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>December 29 1966</b> , and that death occurred at <b>2 A</b> M, from the causes and on the date stated above.   |  |                                  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>L. Myrton Gaines</b>   |  |                                  |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22b. DATE SIGNED <b>1/10/67</b>                |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. L. Myrton Gaines</b>   |  |                                  |  |  |  | 22d. ADDRESS <b>7800 York Rd., Towson 4, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>1-12-67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Union Hill</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Kenneth Square Pa.</b>   |  |  |  |  |  |
| 24. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>  |  |                                  |  |  |  | ADDRESS <b>4905 York Rd. Balto., Md.</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>     |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION



00203

## CERTIFICATE OF DEATH

00205

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission)<br>a STATE <b>Md.</b> b COUNTY <b>Baltimore</b>                      |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21207</b>   |  | c LENGTH OF STAY IN IS<br><b>Baltimore 21207</b>  |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3114 Rolling Road</b>   |  | d STREET ADDRESS<br><b>3114 Rolling Road</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Hattie Lena Bennett</b>   |  | 4 DATE OF DEATH<br>Month <b>Jan.</b> Day <b>22</b> Year <b>19 67</b>  |  |
| 5 SEX<br><b>F</b>   | 6 COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>7/19/1895</b>                                    |
| 9 AGE (In years last birthday)<br><b>71</b> yrs.  |  | 10 UNDER 1 YEAR<br>Months <b>1</b> Days <b>13</b>   |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>South Carolina</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Peale</b>   |  | 14 MOTHER'S MAIDEN NAME<br><b>Sally Odam</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  |
| 17. INFORMANT<br><b>Lawrence H. Calhoun-3114 Rolling Rd. 21207</b>  |  | Address   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY.<br><b>334X</b> IMMEDIATE CAUSE (a) <b>Cerebral Apoplexy - Stroke</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertension</b><br>DUE TO<br>(c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hours</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 11</b> , 19 <b>67</b> to <b>Jan 24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan 21</b> , 19 <b>67</b> , and that death occurred at <b>3:54 A.M.</b> from causes and on the date stated above                                   |  |   |  |
| 22a. SIGNATURE<br><b>Edwin Pierpont</b>   |  | 22b. DATE SIGNED<br><b>1/23/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Edwin Pierpont</b>  |  | 22d. ADDRESS<br><b>8204 Liberty Road-Balt. 21207</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/23/1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Memorial</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Finksburg, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers</b>   |  | 25a. REC'D BY REGISTRAR<br><b>8728 Liberty Rd. Randallstown</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>JAN 25 1967</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers, pages 1 and 2 and in any event, within 72 hours after death.



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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |  |  |   |  |   |  |
|---|--|----------------------------------|--|---|--|--|--|---|--|---|--|
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |  |  |   |  |   |  |
| 00206   |  |                                  |  |   |  |  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u> |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |                                  |  | c. LENGTH OF STAY IN ID   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Annslie</u>   |  |   |  | d. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>GREATER BALTO. MED CTR</u>   |  |                                  |  |   |  | d. STREET ADDRESS<br><u>506 Murdock Rd</u>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>STELLA</u> Middle <u>RAMER</u> Last <u>BENSON</u>   |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month <u>JAN.</u> Day <u>5</u> Year <u>1967</u>  |  |   |  |   |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Oct 24 1891</u>   |  | 9. AGE (In years last birthday)<br><u>75</u> yrs.               |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At home</u>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                      |  |   |  |
| 13. FATHER'S NAME<br><u>Charles Ramer</u>   |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Schwaab</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><u>-</u>   |  | 17. INFORMANT<br>Address <u>21212 Charles T Benson 1628 Ingram Rd</u>  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA</u><br>DUE TO (b) <u>CARCINOMA OF RECTUM.</u><br>DUE TO (c) <u>-</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                  |  |   |  |  |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                  |  |   |  |  |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                                  |  |   |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                            |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30</u> , 19 <u>66</u> , to <u>Jan. 5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5</u> , 19 <u>67</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.                        |  |                                  |  |   |  |  |  |   |  |   |  |
| 22a. SIGNATURE<br><u>John E. Adams, M.D.</u>  |  |                                  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>              |  | 22b. DATE SIGNED<br><u>JAN. 6, 1967</u>                         |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOHN E. ADAMS, M.D.</u>  |  |                                  |  |   |  | 22d. ADDRESS<br><u>GREATER BALTO. MED. CTR.</u>  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremation</u>   |  |                                  |  | 23b. DATE THEREOF<br><u>JAN 6 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>BALTO MD</u> |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Burder Funeral Home</u>  |  |                                  |  |   |  | ADDRESS<br><u>3631 Falls Rd Balto</u>  |  | 25a. REC'D BY REGISTRAR<br><u>John Charles Jones</u>            |  | 25b. REGISTRAR'S SIGNATURE<br><u>John Charles Jones</u>   |  |
| DATE<br><u>JAN 9 1967</u>   |  |                                  |  |   |  |  |  |   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00205

CERTIFICATE OF DEATH

00207

|  |                              |   |                                      |  |   |   |   |
|--|------------------------------|---|--------------------------------------|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                              |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>   |                              | c. LENGTH OF STAY IN Tb<br><u>17 days</u>   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Wings Mills</u>                                       |   | d. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Spring Grove Hosp</u>   |                              |   |                                      | d. STREET ADDRESS<br><u>Fairview Farms</u>   |   |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Dan</u> Middle <u>FRANKLIN</u> Last <u>Billmyer Jr.</u>  |                              |   |                                      | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>22</u> Year <u>1967</u>  |   |   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>7/11/1893</u> |  | 9. AGE (In years last birthday)<br><u>74</u> yrs. | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>             |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><u>RETIRED</u>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>METAL FINISHERS</u>   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><u>MARYLAND</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u>  |   |
| 13. FATHER'S NAME<br><u>Dan F. Billmyer Sr.</u>  |                              |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>Amelia Nancy</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>yes unknown</u>  |                              | 16. SOCIAL SECURITY NO.<br><u>218-09-3492</u>   |                                      | 17. INFORMANT<br>Address <u>W. W. W. Rd</u><br><u>Mrs. Agnes M. Schmidt Randallstown Md.</u>   |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u><br><u>493X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Pneumonia</u> DUE TO (c) <u>  </u> |                              |   |                                      |  |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Chronic Brain Syndrome</u>   |                              |   |                                      |  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> , 19 <u>67</u> , to <u>1/22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>67</u> , and that death occurred at <u>2:20 PM</u> , from causes and on the date stated above.                        |                              |   |                                      |  |   |   |   |
| 22a. SIGNATURE<br><u>Arthur C. Lamb, Jr.</u>   |                              |   |                                      | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>              |   | 22b. DATE SIGNED<br><u>1/22/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Arthur C. Lamb, Jr. M.D.</u>  |                              |   |                                      | 22d. ADDRESS<br><u>Spring Grove Hosp</u>   |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                              | 23b. DATE THEREOF<br><u>Jan. 25, 1967</u>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olivet Cemetery</u>   |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |   |
| 24. FUNERAL DIRECTOR<br><u>Frank Nance Jr. Catonsville Md.</u>   |                              |   |                                      | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 6 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John C. Judge</u>  |   |



FOR STATE HEALTH DEPT.

00206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00208

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <b>BALTIMORE</b><br>MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY                                    |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville</b>   |   | c LENGTH OF STAY IN 1b<br><b>5 yrs</b>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>202 E. Seminary Avenue</b>  |   | d STREET ADDRESS<br><b>202 E. Seminary Avenue</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br><b>MARGARET ADELE E BIRD</b>  |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>1</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>9-7-14</b>  |
| 9 AGE (in years last birthday)<br><b>52 yrs</b>   |   | 10a USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |   |
| 10b KIND OF BUSINESS OR INDUSTRY  |   | 11 BIRTHPLACE (State or foreign country)<br><b>Okalona, Ark</b>  |   |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13 FATHER'S NAME<br><b>J.E.Cooper</b>  |   |
| 14 MOTHER'S MAIDEN NAME<br><b>Velma Young</b>   |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No.</b>                                       |   |
| 16 SOCIAL SECURITY NO.<br><b>577-36-2594</b>  |   | 17 INFORMANT<br><b>Carroll Bird, Lutherville, Md.</b>  |   |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br><b>322.0</b> IMMEDIATE CAUSE (a) <b>Acute ethylism</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |   |
| 20c TIME OF INJURY Month, Day, Year<br>hour o.m. p.m. <b>19</b>   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>of work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>Charles S. Springate, M.D.</b>   |   | 22. DATE SIGNED<br><b>January 1, 1967</b>  |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>   |   | 23a LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md.</b>   |   |
| 23a BURIAL, CREMATION, or other disposal (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>1-4-67</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley</b>   | 23d ADDRESS (Street, city, town, or county)   |
| 24 FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>   |   | 25a REC'D BY REGISTRAR<br>DATE <b>JAN 4 1967</b>   |   |
| 25b REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |   |  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                          |  |   |  |  |  |  |  |   |  |
|--|--|--------------------------|--|---|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                          |  |   |  |  |  |  |  |   |  |
| 00207  |  |                          |  | CERTIFICATE OF DEATH  |  |  |  | 00209  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u><br>c. LENGTH OF STAY IN 1b <u>7 MO 29 DAYS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>                     |  |                          |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u><br>b. COUNTY <u>BALTO CITY</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO.</u><br>d. STREET ADDRESS <u>3830</u> |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)   |  | First <u>Ann</u>         |  | Middle <u>Evans</u>   |  | Last <u>R. B. C. K.</u>  |  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>7</u> Year <u>1967</u>                       |  | 5. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u></u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday) <u>72</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                          |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>              |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <u>George Taylor</u>   |  |                          |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Georgeanna Berry</u>                       |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  |                          |  | 16. SOCIAL SECURITY NO. <u>220-44-8147</u>  |  | 17. INFORMANT <u>Mrs. Georgeanna Carberry, 5960 Daywalt Ave.</u>       |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                          |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u><br><u>unknown</u>                       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>   |  |                          |  |   |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                          |  |   |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |                          |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                          |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (1) (this hospital) attended the deceased from <u>5-9</u> , 1966, to <u>1-7</u> , 1967, that (2) (we) last saw the deceased alive on <u>1-5</u> , 1967, and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above.   |  |                          |  |   |  |  |  |  |  |   |  |
| 22a. SIGNATURE <u>David I. Miller</u>  |  |                          |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  |  | 22b. DATE SIGNED <u>1-7-67</u>   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>David I. Miller</u>  |  |                          |  | 22d. ADDRESS <u>Lisbon Rd. Owings Mills, Md.</u>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                          |  | 23b. DATE THEREOF <u>1/10/67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>         |  | 23d. LOCATION (City, town or county) (State) <u>Pikesville, Balto. Co. Md.</u>         |  |   |  |
| 24. FUNERAL DIRECTOR <u>B. Vernon Lemmons</u>  |  |                          |  |   |  | ADDRESS <u>4611 Park Heights Av. Balto. Md.</u>                        |  | 25a. REC'D BY REGISTRAR <u>JAN 10 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>J. H. ...</u>   |  |



1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00208

CERTIFICATE OF DEATH

00210

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Anne Arundel</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Linthicum Heights - 21090</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | d. STREET ADDRESS<br><b>430 W. Shipley Road</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Ethel</b> Middle <b>C.</b> Last <b>Blumenberg</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>17</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-15-13</b>  |
| 9. AGE (In years lost birthday) yrs. <b>53</b>   |  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>17</b> Hours <b>19</b> Min. <b>67</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ohio (Limaville)</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>Jesse D. Clark</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Grace Green</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>300-01-0178</b>  |   |
| 17. INFORMANT<br><b>Mr. Karl E. Blumenberg (Husband)</b>   |  | Address <b>Same as #2</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Generalized peritonitis</b><br>DUE TO<br>(b) <b>acute appendicitis.</b><br>DUE TO<br>(c) <b>550.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Uremia due to chronic glomerulonephritis</b>  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>NO</b> (this hospital) attended the deceased from <b>Jan. 9</b> , 19 <b>67</b> , to <b>Jan. 17</b> , 19 <b>67</b> , that <b>NO</b> (we) last saw the deceased alive on <b>Jan. 17</b> , 19 <b>67</b> , and that death occurred at <b>11:50</b> M, from causes on and on the date stated above.                     |  |   |   |
| 22a. SIGNATURE<br><b>Lawrence F. Misanik, M.D.</b>   |  | 22b. DATE SIGNED<br><b>January 18, 1967</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence F. Misanik, M.D.</b>   |  | 22d. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jan. 21, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Baven Memorial Pk.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, Maryland</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Eugene B. Fleming</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 19 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00209

## CERTIFICATE OF DEATH

00211

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>LONDON</b><br>c. LENGTH OF STAY IN 1b <b>3 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MED. CTR.</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>d. STREET ADDRESS <b>933 W. LOMBARD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CÉCELIA</b> Middle <b>BERTHA</b> Last <b>BOLTON</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>30</b> Year <b>1967</b>   |  |   |  |
| 5. SEX <b>F</b>   |  | 6. COLOR OR RACE <b>CAU</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>9-13-03</b>                                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>  |  | 11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                        |  |
| 13. FATHER'S NAME <b>JACOB KOWALEWSKI</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>FELYICA KOWALEWSKI</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>  |  | 16. SOCIAL SECURITY NO. <b>220-24-2086</b>  |  | 17. INFORMANT <b>DOROTHY WITHROW</b><br>(Daughter)  |  | Address <b>1044 W. LOMBARD ST. BALTO., MD.</b>                    |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Infarction</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarction</b><br>(c) <b>Arteriosclerotic Cardiovascular Disease</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                              |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-28</b> , 19 <b>67</b> , to <b>1-30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-30</b> , 19 <b>67</b> , and that death occurred at <b>4 P.M.</b> , from the causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE <b>M. A. Gongon</b>  |  |   |  | 22b. DATE SIGNED <b>1-30-67</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>MANUEL A. GONGON</b>              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF <b>2/3/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>LONDON PARK CEM.</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Baltimore Md.</b> |  |
| 24. FUNERAL DIRECTOR <b>John J. Cowan &amp; Sons</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>Hollins St.</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                   |  |



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00210

CERTIFICATE OF DEATH

00212

|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b><br>c. LENGTH OF STAY IN b<br><b>269 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b> |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>WICOMICO</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>SALISBURY</b><br>d. STREET ADDRESS<br><b>610 SOUTH DIVISION STREET</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>LEONARD - - - BOZMAN</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 27 1967</b>  |  |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>JULY 15, 1891</b>  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WATERMAN</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>PRINCESS ANNE, MARYLAND</b> |
| 13 FATHER'S NAME<br><b>EMORY BOZMAN</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or Unknown) (If yes give war or dates of service)<br><b>YES WW I</b>   |   | 16. SOCIAL SECURITY NO.<br><b>220 10 95 04</b>  |  |
| 17. INFORMANT<br><b>VA HOSPITAL</b>   |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br><del>MYOCARDIAL INFARCTION</del><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO<br>(c) <b>ARTERIOSCLEROSIS MARKED GENERALIZED</b>                           |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b><br><b>RECENT &amp; OLD</b><br><b>UNKNOWN</b>  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>BENIGN PROSTATIC HYPERTROPHY. DIABETES MELLITUS, CLINICAL</b>  |   |   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)  |
| 21. I certify that (this hospital) attended the deceased from <b>MAY 3</b> , 19 <b>66</b> , to <b>JAN. 27</b> , 1967, that (we) last saw the deceased alive on <b>JAN. 27</b> , 19 <b>67</b> , and that death occurred at <b>8:40 PM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><i>George Dudas</i> , M.D.  |   | 22b. DATE SIGNED<br><b>1/30/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, M. D.</b>  |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>2/1/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>          |
| 24. FUNERAL DIRECTOR<br><i>173 Zannino</i>  |   | 25a. REC'D BY REGISTRAR<br><b>FEB 1 1967</b><br>DATE<br><b>257 S. Conkling St. Baltimore, Md.</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>James Judge</i>  |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

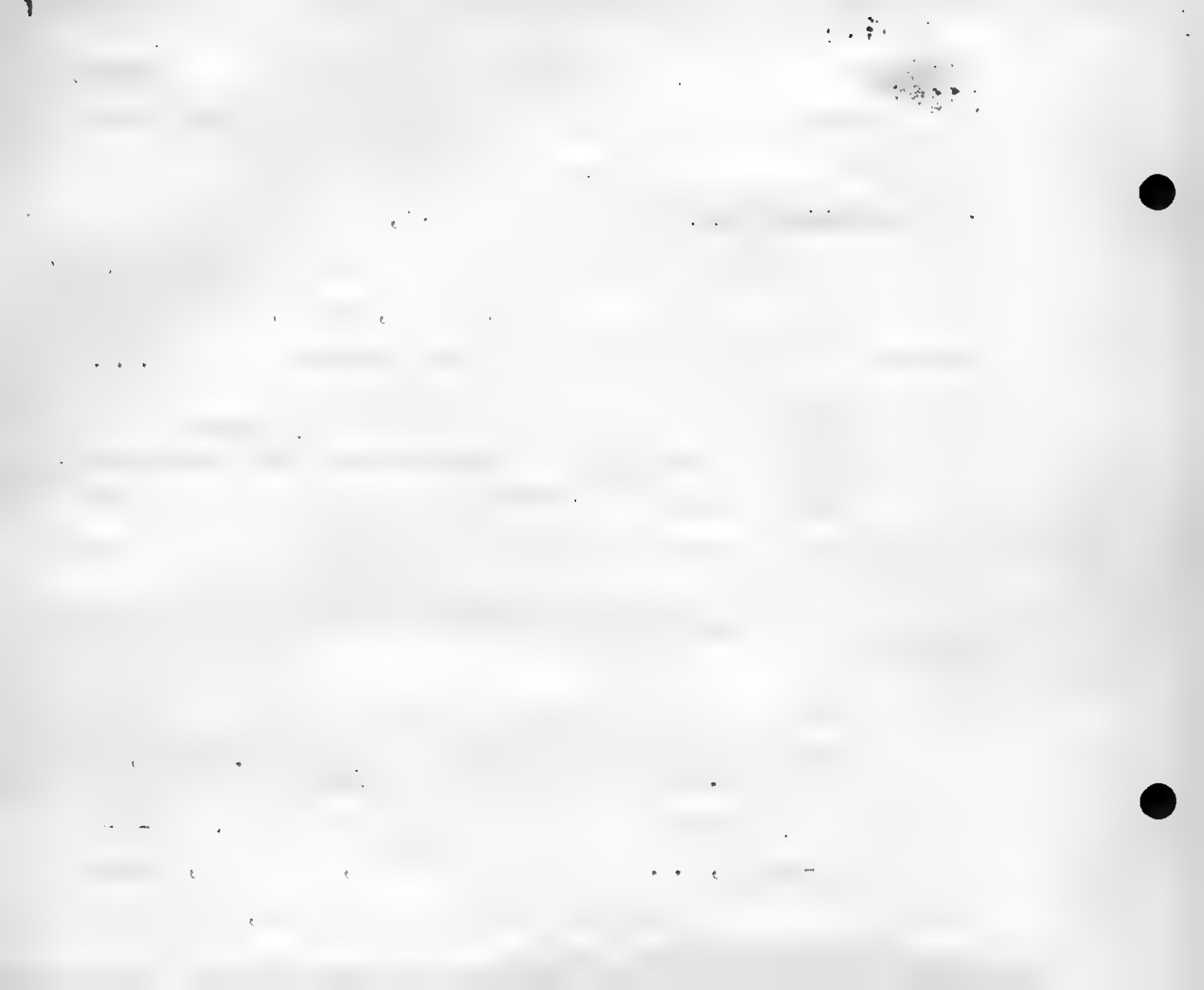
CERTIFICATE OF DEATH

00213

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>84 DAYS</b>   | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>LAUREL</b>         |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>ROUTE 2, BOX 2A</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>ELMER THOMAS BROWN</b>  |  | 4. DATE OF DEATH Month Day Year<br><b>JANUARY 27 19 67</b>  |  |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | B. DATE OF BIRTH<br><b>SEPTEMBER 1, 1892</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PAINTER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday) <b>74</b> yrs<br>IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>LAUREL, MARYLAND</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>BENJAMIN BROWN</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH SMITH</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>   |  | 16. SOCIAL SECURITY NO<br><b>219 05 77 87</b>   |  |
| 17. INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BILATERAL BRONCHOPNEUMONIA</b><br><b>151X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF STOMACH</b> DUE TO<br>(c) <b>UNKNOWN</b> |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>RECENT MYOCARDIAL INFARCTION</b>   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <b>MY</b> (this hospital) attended the deceased from <b>NOV 1</b> , 19 <b>66</b> , to <b>JAN. 27</b> , 19 <b>67</b> that <b>MY</b> (we) last saw the deceased alive on <b>JAN. 27</b> , 19 <b>67</b> , and that death occurred at <b>5:45 PM</b> , from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>Z. S. Tao</b>  |  | 22b. DATE SIGNED<br><b>1-27-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>ZUI-SUN TAO, M.D.</b>  |  | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1-31-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST MARY'S CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>LAUREL, MARYLAND</b>                                 |
| 24 FUNERAL DIRECTOR<br><b>DEWITT DONALDSON</b>  |  | 25a. REC'D BY REGISTRAR<br><b>DATE FEB 6 1967</b>   |  |
| 313 TALBOT AVENUE, LAUREL, MARYLAND   |  | 25b. REGISTRAR'S SIGNATURE<br><b>G. J. ...</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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00212

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00214

|   |                                  |   |  |   |  |
|---|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>   |                                  | c. LENGTH OF STAY IN 1b   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Balto.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>101 Butler Road</b>   |                                  |   |  | d. STREET ADDRESS <b>101 Butler Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elwood</b> Middle <b>Eugene</b> Last <b>Brown</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>25</b> Year <b>19 67</b> |   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>Dec. 7, 1931</b>                                     | 9. AGE (In years last birthday) <b>35</b> yrs   | IF UNDER 1 YEAR<br>Months <b>35</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Heavy Machine Operator</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Hampstead, Md.</b>   |  |
| 13. FATHER'S NAME <b>Havern Brown</b>   |                                  |   | 14. MOTHER'S MAIDEN NAME <b>Wiona Martin</b>                             |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b><br>(If yes give war or dates of service) <b>Korean</b>   |                                  | 16. SOCIAL SECURITY NO <b>212-30-5954</b>   |  | 17. INFORMANT <b>Mrs. Mary A. Brown</b><br>Address <b>Reisterstown, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>153.5</b> IMMEDIATE CAUSE (a) <b>Carcinoma - Colon &amp; metastasis</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>September 19 66</b> to <b>January 25 19 67</b> , that (I) (we) last saw the deceased alive on <b>January 25 19 67</b> , and that death occurred at <b>7:25 AM</b> , from causes and on the date stated above.  |                                  |   |  |   |  |
| 22a. SIGNATURE <b>Charles E. McWilliams M.D.</b>  |                                  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED <b>1-26-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)  |                                  | 22d. ADDRESS <b>11904 Reisterstown Rd Reisterstown Md</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>1/28/67</b> | 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore Co. Md.</b>  |  |
| 24. FUNERAL DIRECTOR <b>J. F. Eline &amp; Sons Reisterstown, Md.</b>  |                                  | ADDRESS   |  | 25a. REC'D BY REGISTRAR <b>JAN 30 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>J. F. Eline</b>  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                  |                             |   |   |  |  |   |      |  |  |
|--|--|------------------|-----------------------------|---|---|--|--|---|------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |                             |   |   |  |  |   |      |  |  |
| 00213  |  |                  |                             |   | 00215   |  |  |   |      |  |  |
| 1. PLACE OF DEATH  |  |                  |                             |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)         |  |  |   |      |  |  |
| a. COUNTY<br>Baltimore   |  |                  |                             |   | a. STATE<br>Maryland  |  |  |   |      |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Parkville  |  |                  |                             |   | b. COUNTY<br>Balto.   |  |  |   |      |  |  |
| c. LENGTH OF STAY IN 1b  |  |                  |                             |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Parkville |  |  |   |      |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>7803 Old Harford road  |  |                  |                             |   | d. STREET ADDRESS<br>7803 Old Harford road  |  |  |   |      |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |                             |   |   |  |  |   |      |  |  |
| 3. NAME OF DECEASED (Type or print)  |  |                  | First                       |   |   | Middle   |  |   | Last |  |  |
|  |  |                  | VIRGINIA C.                 |   |   | BRUCK  |  |   |      |  |  |
| 5. SEX   |  | 6. COLOR OR RACE |                             | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                                |   | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)                                       |      | 10. IF UNDER 1 YEAR                          |  |
| F  |  | W                |                             | WIDWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                              |   | June 9 1910  |  | 56 yrs.   |      | Months Days Hours Min.                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>at home   |  |                  |                             | 10b. KIND OF BUSINESS OR INDUSTRY   |   |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>North Carolina |      | 12. CITIZEN OF WHAT COUNTRY?<br>USA          |  |
| 13. FATHER'S NAME<br>Carroll Clark   |  |                  |                             |   |   | 14. MOTHER'S MAIDEN NAME<br>Myrtle Rice                                |  |   |      |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)<br>No  |  |                  |                             | 16. SOCIAL SECURITY NO.<br>220-44-6643  |   |  |  | 17. INFORMANT<br>Family Records                                       |      |  |  |
|  |  |                  |                             | Address   |   |  |  |   |      |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) carcinoma lung  |  |                  |                             |   |   |  |  |   |      | INTERVAL BETWEEN ONSET AND DEATH<br>4 months |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last,<br>DUE TO (b)<br>DUE TO (c)   |  |                  |                             |   |   |  |  |   |      |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                  |                             |   |   |  |  |   |      |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |                  |                             |   |   |  |  |   |      |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                  |                             | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |   |  |  |   |      |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19   |  |                  |                             | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)                                  |      |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from 4-3-1965, to 1-30-1967 that (I) (we) last saw the deceased alive on 12-30-1967, and that death occurred at 7 PM, from the causes and on the date stated above. |  |                  |                             |   |   |  |  |   |      |  |  |
| 22a. SIGNATURE<br>E. E. Ellsworth Cook   |  |                  |                             |   |   |  |  |   |      | 22b. DATE SIGNED<br>1-31-67                  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>E. E. Ellsworth Cook M.D.  |  |                  |                             |   |   |  |  |   |      | 22d. ADDRESS<br>2431 Maryland Ave.           |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |                  | 23b. DATE THEREOF<br>2/2/67 |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Moreland Mem Park                                       |  |  | 23d. LOCATION (City, town or county) (State)<br>Balto Co Md.          |      |  |  |
| 24. FUNERAL DIRECTOR<br>C.F. EVANS & SON 8802 Harford road   |  |                  |                             |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 2 1967                             |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. J. J.                             |      |  |  |



## CERTIFICATE OF DEATH

00216

00214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                     |  |   |
|---|-------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore - 21224</b><br>d. STREET ADDRESS<br><b>7 Ellwood Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Frederick &amp; H. Buettner</b>   |                                     | 4 DATE OF DEATH<br>Month Day Year<br><b>January 15, 1967</b>   |   |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>     | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>July 17, 1889</b><br>9 AGE (n years last birthday) yrs<br><b>77</b>         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired:</b><br><b>Building Superintendent</b>  |                                     | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b><br>12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13. FATHER'S NAME<br><b>Frederick Buettner</b>  |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Clara ?</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>276-10-9074A</b><br>17. INFORMANT<br><b>Mrs. Lillian Buettner</b><br>Address<br><b>7 N. Ellwood Ave</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b><br>153.3 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Perforation of Adenocarcinoma of Sigmoid Colon</b><br>DUE TO<br>(c) _____   |                                     |  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |                                     |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>January 12, 1967</b> , to <b>January 15, 1967</b> , that <b>he</b> (we) last saw the deceased alive on <b>January 15, 1967</b> , and that death occurred at <b>3:25 P.</b> from causes and on the date stated above.   |                                     |  |   |
| 22a. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M. D.</b>  |                                     | 22b. DATE SIGNED<br><b>January 15, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M. D.</b>  |                                     | 22d. ADDRESS<br><b>7620 York Road, Towson 4, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/19/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Sacred Heart of Jesus</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>John A. Moran, Inc.</b>  |                                     | 25a. REC'D BY REGISTRAR<br><b>AN 18 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00215

CERTIFICATE OF DEATH

00217

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |   | c. LENGTH OF STAY IN 1b<br><u>3 mos.</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Towson Nursing Home</u>   |   | d. STREET ADDRESS<br><u>11. Vista Road Kingsville</u>   |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>Marie Burgerding</u>  |   | 4. DATE OF DEATH<br>Month Day Year<br><u>1 23 19 67</u>   |  |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>8-26-1897</u>                                 |
| 9. AGE (In years last birthday)<br><u>69</u> yrs   |   | 10. IF UNDER 1 YEAR Months Days Hours Min<br><u>1 23 19 67</u>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Housewife</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Maryland</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>Fredrick L. Frey</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Pauline C. Eakes</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>212 4 1325</u>   |  |
| 17. INFORMANT<br><u>Mrs. Margaret Hess 8809 Ashford Road 34</u>  |   | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastro intestinal hemorrhage</u><br>154X DUE TO <u>Carcinoma of rectum - widespread metastases</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>4 hrs</u><br><u>3 yrs</u>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                 |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>65</u> , to <u>Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 21</u> 19 <u>67</u> , and that death occurred at <u>7:40 A</u> M, from causes and on the date stated above |   |   |  |
| 22a. SIGNATURE<br><u>Charles M. Kerr</u>   |   | 22b. DATE SIGNED<br><u>1-24-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Charles M. Kerr</u>   |   | 22d. ADDRESS<br><u>6801 Belvoir Rd Baltimore 6 Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF<br><u>1-26-1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Md</u> |
| 24. FUNERAL DIRECTOR<br><u>Lassahn Funeral Home 7401 Belvoir Road</u>  |   | 25a. REC'D BY REGISTRAR<br><u>36</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | DATE<br><u>JAN 25 1967</u>  |  |



00216

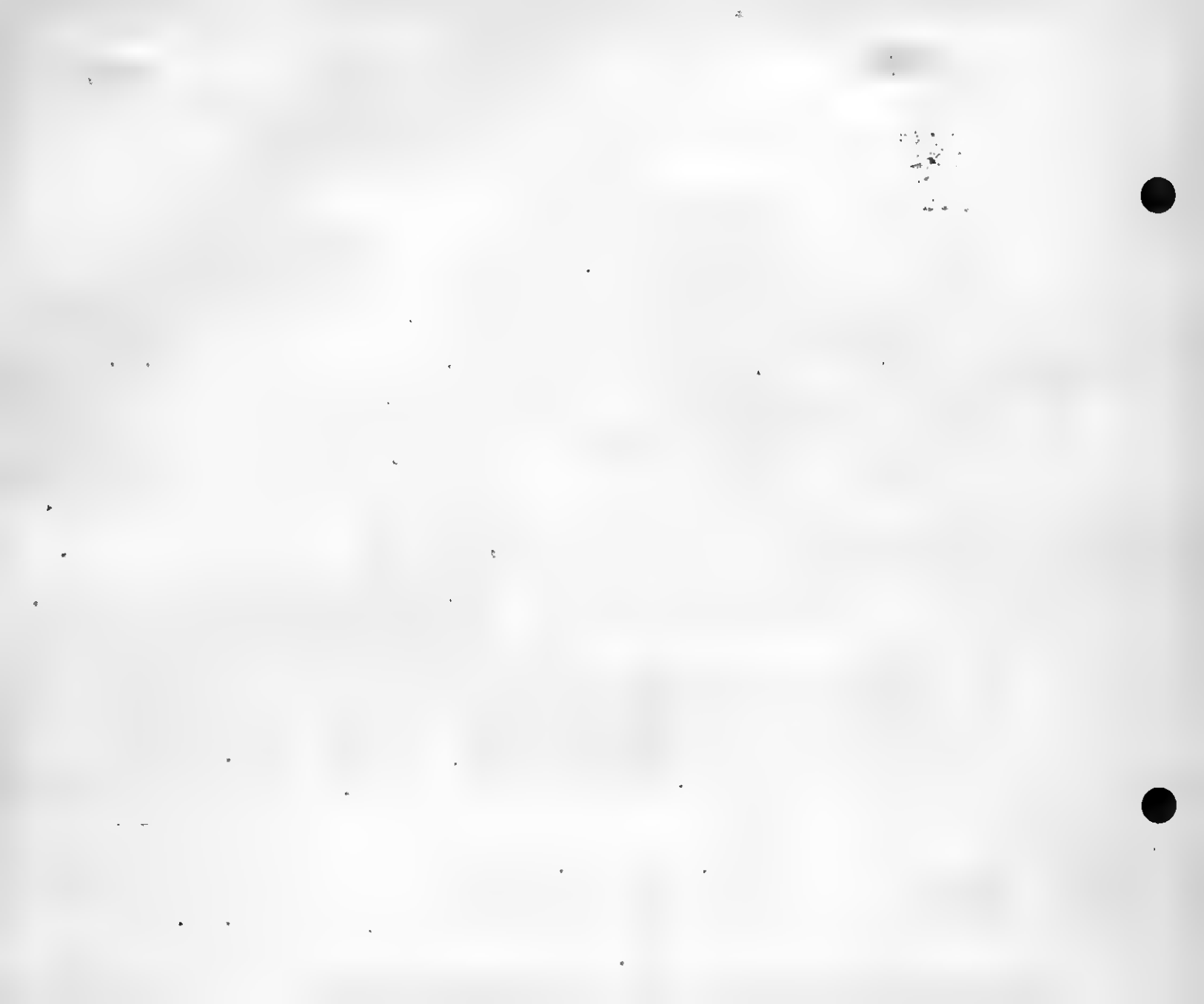
CERTIFICATE OF DEATH

00218

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>10mth 22dys</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |  | e. STREET ADDRESS<br><b>1421 Hill Street</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary Louise</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>July 19, 1910</b>                           |
| 9. AGE (In years last birthday)<br><b>56 yrs</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife Sect.</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Office</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>George Walfer</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Carrie</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>212-01-9953</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X Uremia</b><br>(b) <b>Pyelonephritis, chronic</b><br>(c) <b>Diabetes Mellitus, poorly controlled</b>                            |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b><br><b>1 yr.</b><br><b>20 yrs.</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                               |
| 21. I certify that (this hospital) attended the deceased from <b>Feb. 11, 1966</b> to <b>Jan. 6, 1967</b> , that (he) (we) last saw the deceased alive on <b>Jan. 6, 1967</b> , and that death occurred at <b>1:30</b> M, from causes and on the date stated above. |  |   |  |
| 22a. SIGNATURE<br><b>Anthony J. Young, M.D.</b>   |  | 22b. DATE SIGNED<br><b>1-6-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1 10 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Mc Cully</b>   |  | ADDRESS<br><b>130 E. Fort Age</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>JAN 9 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





00217

## CERTIFICATE OF DEATH

00219

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>BALTIMORE</u>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FEETAL - MONKTON</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL - MONKTON</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Monkton Rd., Near Old York Rd.</u>   |   | d. STREET ADDRESS<br><u>Monkton Rd., near Old York Rd.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>HARRY G. CANNADAY</u>   |   | 4. DATE OF DEATH <u>JAN. 2</u> 19 <u>67</u>   |  |
| 5. SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1895</u><br><u>NOV. 23, 1903</u>                                   |
| 9. AGE (in years last birthday) <u>71</u> yrs   |   | 10. IF UNDER 1 YEAR: Months _____ Days _____ Hours _____ Min _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>FARMER - RETIRED</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>SELF EMPLOYED</u>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>VIRGINIA</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>ISAAC T. CANNADAY</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>LUCY PETERS</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>FAMILY RECORDS</u>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>1/22/1</u> IMMEDIATE CAUSE (a) <u>Bacterial - PNEUMONIA</u><br>DUE TO (b) <u>A.S.C.V.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hrs.</u>                                     |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Diabetes Mellitus</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>67</u> , to <u>1/2/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/2/67</u> 19____, and that death occurred at <u>10 P.M.</u> from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><u>G. H. F. Rance</u>   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        | 22b. DATE SIGNED<br><u>1/3/67</u>  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>A. H. J. RANCE</u>   |   | 22d. ADDRESS<br><u>777 K 704 Rd.</u>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>JAN. 5, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ST. JAMES CEMETERY</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>MONKTON, BALTOCO, MD.</u>          |
| 24. FUNERAL DIRECTOR<br><u>John Burno' Sons, Towson, Md.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 9</u> 19 <u>67</u>   | 25b. REGISTRAR'S SIGNATURE<br><u>John Burno' Sons</u>                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

12/25

12/25



00218

CERTIFICATE OF DEATH

00220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>                               |  | c. LENGTH OF STAY IN 1b<br><b>56 DAYS</b>  |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  |  |  | d. STREET ADDRESS<br><b>3026 BAKER STREET</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>ROBERT WALTER CARRINGTON</b>  |  | 4. DATE<br>DEATH<br><b>JANUARY 5 19 67</b>   |  | 5 SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>NEGRO</b>   |  |
| 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH<br><b>FEBRUARY 28, 1942</b>   |  | 9 AGE (In years last birthday) yrs.<br><b>24</b>   |  | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Stock boy</b> |  | 10b K ND OF BUSINESS OR INDUSTRY   |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13 FATHER'S NAME<br><b>JOHN CARRINGTON</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>AMIE PEGRAM</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES</b>  |  | 16. SOCIAL SECURITY NO<br><b>214 38 60 61</b>  |  | 17. INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>                                     |  | 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BILATERAL LOBAR PNEUMONIA</b><br>DUE TO (b) _____<br>DUE TO (c) <b>MULTIPLE SCLEROSIS</b> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                         |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f (City or town) (County) (State)  |  |
| 21. I certify that (H) (this hospital) attended the deceased from <b>NOV 10</b> , 19 <b>66</b> to <b>JAN 5</b> , 19 <b>67</b> , that (H) (we) last saw the deceased alive on <b>JAN 5</b> , 19 <b>67</b> , and that death occurred at <b>9:45A</b> M, from causes and on the date stated above. |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><i>He-lan he-lan</i>  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/6/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M. D.</b>   |  |
| 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  |  |  |  |  |
| 23b. DATE THEREOF<br><b>1-10-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE, NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                                    |  | 24. FUNERAL DIRECTOR<br><b>CHARLES R. LAW FUNERAL HOME</b>   |  |
| 25a. REC'D BY REGISTRAR<br><b>9 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |  |  |  |  |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00219

CERTIFICATE OF DEATH

00221

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>—</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>8 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | e. STREET ADDRESS<br><b>128 E. BARNEY STREET</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>LAWRENCE</b> Middle <b>L.</b> Last <b>CATLETT</b>  |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>23</b> Year <b>67</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/28/18</b>  |
| 9. AGE (In years birthday) <b>48</b> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <b>—</b> Days <b>—</b>  | 11. IF UNDER 24 HRS<br>Hours <b>—</b> Min. <b>—</b>                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SOLDIER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>ARMY</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>CLARENCE CATLETT</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELLEN CHILDRESS</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>YES PL 28</b>  |  | 16. SOCIAL SECURITY NO.<br><b>216 01 86 97</b>  |   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RIGHT LOWER LOBE PNEUMONIA, UNDETERMINED ORGANISM</b><br>DUE TO <b>HEPATIC FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>LAENNEC'S CIRRHOSIS</b><br>DUE TO <b>LAENNEC'S CIRRHOSIS</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>2</b><br><b>?</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>ARTERIOSCLEROTIC HEART DISEASE. CHRONIC ALCOHOLISM. CHR. PANCREATITIS.</b>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m. <b>—</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> hot While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>4</b> (this hospital) attended the deceased from <b>1/15/67</b> , 19 <b>67</b> to <b>1/23/67</b> , 19 <b>67</b> , that <b>4</b> (we) last saw the deceased alive on <b>1/23/67</b> , 19 <b>67</b> , and that death occurred at <b>12:10PM</b> on <b>1/23/67</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><i>Neilon Neilson</i>   |  | 22b. DATE SIGNED<br><b>1/23/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILON NEILSON, M. D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1 27 67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>MC CULLY FUNERAL HOME</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00220

CERTIFICATE OF DEATH

00222

|  |  |   |  |   |  |  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u> |  | c. LENGTH OF STAY IN 1b <u>15 Yrs.</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>BALTO.</u> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLS TOWN</u>   |  | d. STREET ADDRESS <u>Box 185 Liberty Road</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Carlton E Charnock</u>  |  | 4 DATE OF DEATH<br>Month <u>1</u> Day <u>10</u> Year <u>1967</u>                                      |  | 5 SEX <u>M</u>  |  | 6 COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. AGE (In years last birthday) <u>50</u> yrs.  |  | 9. IF UNDER 1 YEAR<br>Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min <u>10</u>                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Plant Cold Storage</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Virginia</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  | 3 FATHER'S NAME <u>Charles Howard Charnock</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Maqqie Dize</u>   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>no</u>                    |  |
| 16. SOCIAL SECURITY NO. <u>14-16-3631</u>  |  | 17. INFORMANT <u>Hosp. Record</u>   |  | 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br><u>163X</u><br>IMMEDIATE CAUSE (a) <u>Ray of fracture of PA. A. 10-5</u><br>DUE TO (b) <u>METASTASIS, GA OF TH. A. 10-5</u><br>DUE TO (c) <u>lost.</u> |  | INTERVAL BETWEEN ONSET AND DEATH <u>5-4</u>  |  | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                           |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)          |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work                                    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-27-1966</u> , to <u>1-10-1967</u> , that (I) (we) lost the deceased alive on <u>1-10-1967</u> , and that death occurred at <u>4:00 A.M.</u> , from causes on and on the date stated above. |  | 22a. SIGNATURE <u>Dr. Charles Judge</u>   |  | 22b. DATE SIGNED <u>1-10-67</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles Judge</u>  |  | 22d. ADDRESS <u>5629 Liberty Rd</u>   |  | 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>                               |  | 23b. DATE THEREOF <u>1-12-1967</u>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>  |  | 23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>                                     |  | 24. FUNERAL DIRECTOR <u>J. Howard &amp; Son 3207 W. North Ave</u>   |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  | DATE <u>JAN 11 1967</u>   |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

00221

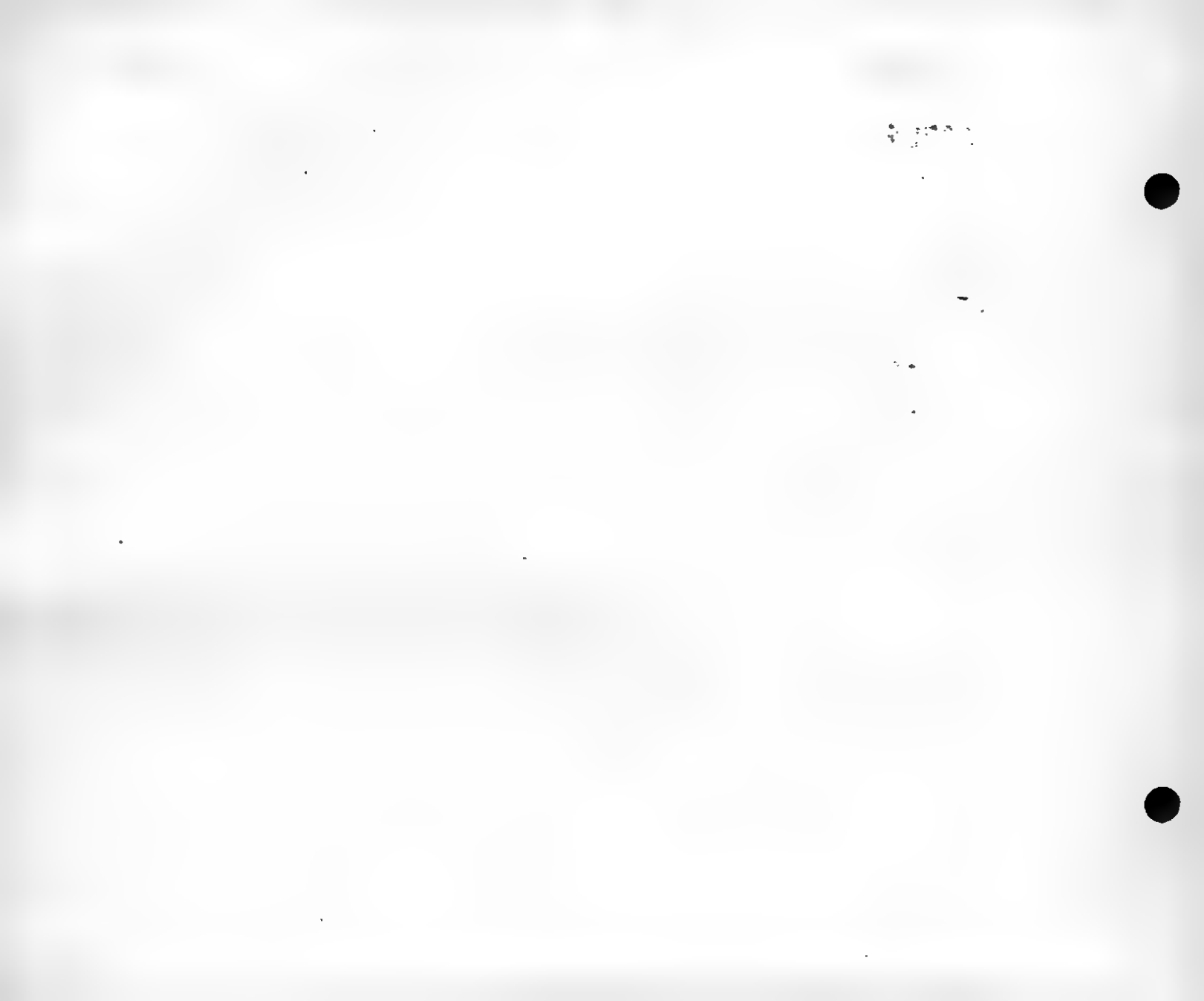
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00223

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE</u> 12   |   | c. LENGTH OF STAY IN 1b<br><u>12</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>316 CASTLE DRIVE</u>   |   | e. STREET ADDRESS<br><u>516 CASTLE DRIVE</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>ELIZABETH</u> Middle <u>C.</u> Last <u>CHARSHA</u>  |   | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>29</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>SEPT. 23, 1882</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>  | 9. AGE (In years last birthday) yrs <u>84</u>   |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>ALFRED W. CURRY</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>MARY A. QUIBLEY</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u> <u>NONE</u>  |   | 16. SOCIAL SECURITY NO.<br><u>220-44-0857</u>   |   |
| 17. INFORMANT<br><u>FAMILY RECORDS</u>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u><br><u>331X</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <u>HYPERTENSIVE CEREBRO-VASCULAR DISEASE</u><br>DUE TO<br>(c) _____  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 YRS.</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> m. p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <u>William A. Pillsbury</u> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <u>WILLIAM A. PILLSBURY</u>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>ENTOMBMENT</u>  |   | 23b. DATE THEREOF<br><u>2-2-67</u>  |   |
| 24. FUNERAL DIRECTOR<br><u>John Burns Sons</u>  |   | 25a. REC'D BY REGISTRAR<br><u>Tolson, Md.</u>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>GREEN MOUNT MAUSOLVM</u>   |   | 23d. LOCATION (City or town) (County) (State)<br><u>BALTO. MD.</u>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   | 22. DATE SIGNED<br><u>1/30/67</u>   |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00222

## CERTIFICATE OF DEATH

00224

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Rural)</b><br>c. LENGTH OF STAY IN 1b<br><b>Baltimore, 21234</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b> |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY _____<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21234</b><br>d. STREET ADDRESS <b>6908 Old Harford Rd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Margaret</b> Middle <b>Emma</b> Last <b>Chelton</b>   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>27</b> Year <b>19 67</b>   |  |
| 5. SEX <b>Female</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>3/5/91</b>   |
| 9. AGE (in years last birthday) <b>75</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months _____ Days _____ Hours _____ Min. _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY _____  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>William Murphy</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Bridget Kelly</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) _____   |   | 16. SOCIAL SECURITY NO. <b>220-12-5671</b>   |  |
| 17. INFORMANT <b>Mr. George W. Chelton</b>  |   | Address <b>(Same)</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>331X</b> IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____     |   |  | INTERVAL BETWEEN ONSET AND DEATH _____   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Nat' While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____   | 20f. (City or town) (County) (State) _____   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 16</b> , 19 <b>67</b> , to <b>Jan. 27</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 27</b> , 19 <b>67</b> , and that death occurred at <b>9:45 PM</b> , from causes and on the date stated above.                       |   |  |  |
| 22a. SIGNATURE <b>M. Y. Chang</b>   |   | 22b. DATE SIGNED <b>Jan. 27 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Myung Y. Chang</b>  |   | 22d. ADDRESS <b>7620 York Rd. Baltimore, Md. 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>1/31/67.</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Holy Cross Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>                            |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |   | 25a. REC'D BY REGISTRAR <b>JAN 31 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |   |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

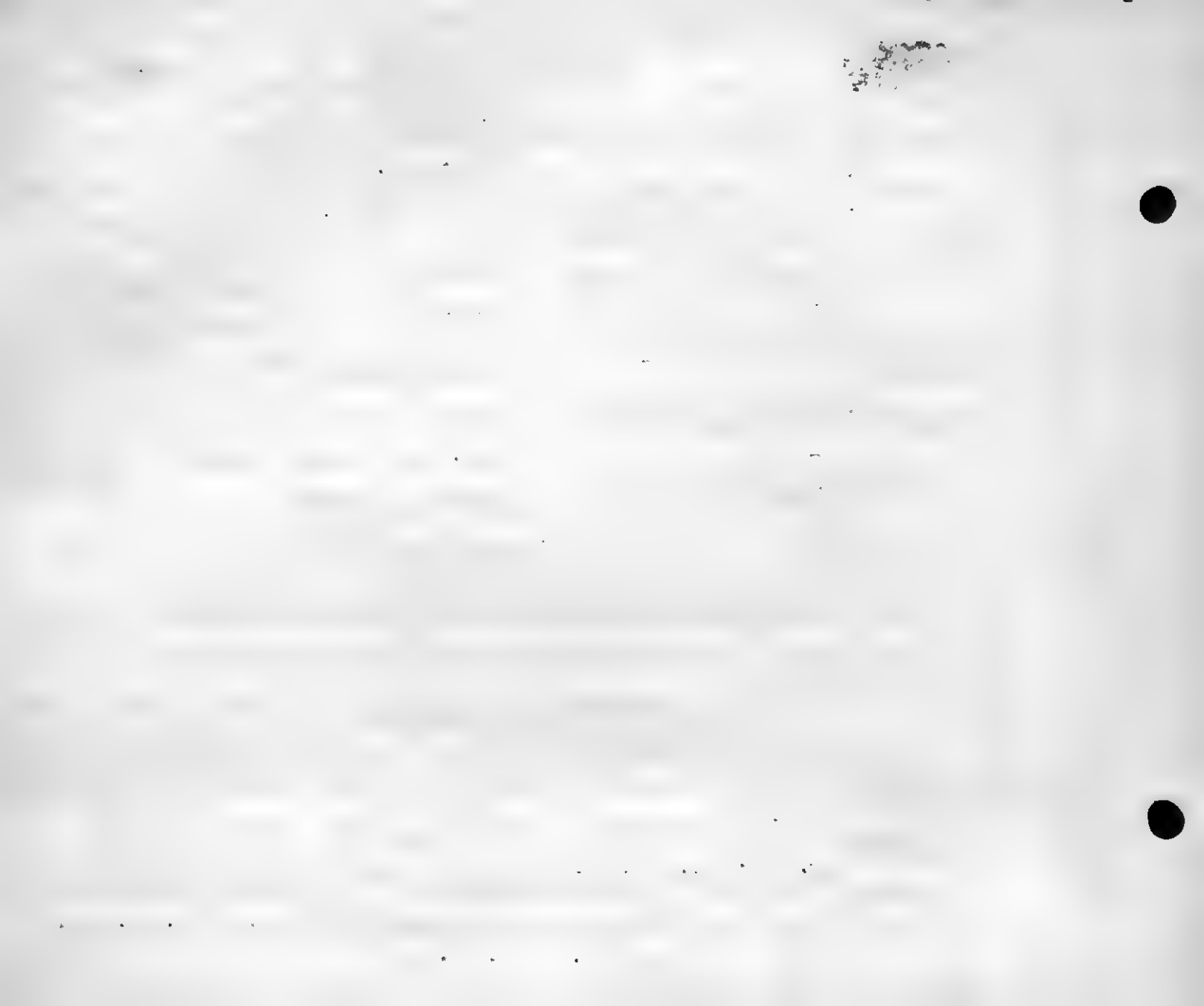
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00223

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00225

|  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |
|--|--|--|--|--|--|--|--|--|--|--------------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b><br>c. LENGTH OF STAY IN 1b <b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Dulaney Towson Nursing Home, 111 West Rd</b>   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>—</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>3115 Keswick Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |                                      |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MARY</b> Middle <b>E.</b> Last <b>CHENOWITH</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>2</b> Year <b>1967</b> |  | 5. SEX <b>Female</b>   |  | 6. COLOR OR RACE <b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-14-1880</b> |  | 9. AGE (In years last birthday) <b>86</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>   |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Warrenton, Virginia</b> |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |                                      |  |  |  |
| 13. FATHER'S NAME <b>Alexander M. Edwards</b>  |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mary Catherine Gray</b>                            |  |  |  |                                      |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO. <b>—</b>   |  | 17. INFORMANT <b>John A. Chenowith, 3725 Delverne Rd 21218</b> Address         |  |  |  |                                      |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRO-VASCULAR ACCIDENT</b><br>331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b><br>(b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |  |  |  |  |  |  |  |                                      |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b><br><b>YEARS.</b>                                    |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |
| MEDICAL CERTIFICATION<br>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |  |  |  |  |  |  |  |  |                                      |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>7/13</b> , 19 <b>65</b> , to <b>1/2</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>66</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |
| 22a. SIGNATURE <b>Donald L. Somerville</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/><br>22b. DATE SIGNED <b>1/4/67</b><br>22c. PHYSICIAN'S NAME (Type) <b>Dr. Donald L. Somerville</b><br>22d. ADDRESS <b>25 W. Pennsylvania Ave., Towson 21204</b>   |  |  |  |  |  |  |  |  |  |                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |  |  | 23b. DATE THEREOF <b>6 Jan 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>               |  | 23d. LOCATION (City, town or county) (State) <b>Woodlawn, Balto. Co., Md.</b>  |  |                                      |  |  |  |
| 24. FUNERAL DIRECTOR <b>Burgee Funeral Home, 3631 Falls Rd. Balto. Md.</b>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR <b>JAN 5 1967</b>                                      |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |                                      |  |  |  |
| By: <b>Hattie Burgee Jr</b>  |  |  |  |  |  |  |  |  |  |                                      |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |  |  |   |  |   |  |   |  |
|---|--|----------------------------------|--|--|--|---|--|---|--|---|--|
| 00224 CERTIFICATE OF DEATH 00226  |  |                                  |  |  |  |   |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE, MARYLAND</u>   |  |                                  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u> |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  |                                  |  | c. LENGTH OF STAY IN ID<br><u>3 days</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Preston MARYLAND</u>                                 |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater BALTIMORE Medical</u>  |  |                                  |  |  |  | d. STREET ADDRESS   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br><u>CATHERINE First MARIE Middle Center Last CLARK</u>  |  |                                  |  |  |  | 4. DATE OF DEATH<br>Month <u>JANUARY</u> Day <u>22</u> Year <u>1967</u>   |  |   |  |   |  |
| 5. SEX<br><u>FEMALE CAUC</u>  |  | 6. COLOR OR RACE<br><u>WHITE</u> |  | 7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED |  | 8. DATE OF BIRTH<br><u>3/14/95</u>  |  | 9. AGE (In years last birthday)<br><u>70</u> yrs. |  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>EAST New Market</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>John T. Schmick</u>   |  |                                  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Satherine M. MAN</u>   |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u>  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><u>219-14-3750</u>  |  | 17. INFORMANT<br><u>PATIENTS</u>  |  |   |  | Address<br><u>CHART</u>   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Aspiration Pneumonia</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <u>state of unconsciousness</u><br>DUE TO (c) <u>Ruptured Cerebral Aneurysm</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |  |  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                  |  |  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)              |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JAN - 19</u> , 19 <u>67</u> , to <u>JAN. 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> 19 <u>67</u> , and that death occurred at <u>1050 PM</u> , from the causes and on the date stated above.   |  |                                  |  |  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><u>M. A. Gongon</u>   |  |                                  |  |  |  | 22b. DATE SIGNED  |  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>MANUEL A. GONGON</u>   |  |                                  |  |  |  | 22d. ADDRESS<br><u>  </u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  |  | 23b. DATE THEREOF<br><u>Jan. 25, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Hill Crest Cemetery</u>  |  |   |  | 23d. LOCATION (City, town or county) (State)<br><u>Federalburg, Maryland</u>                      |  |
| 24. FUNERAL DIRECTOR<br><u>J. J. Frampton and Son, Federalburg, Maryland</u>  |  |                                  |  |  |  | 25a. REC'D BY REGISTRAR<br><u>  </u>  |  |   |  |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |                                  |  |  |  | DATE<br><u>FEB 1 1967</u>   |  |   |  |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00225

## CERTIFICATE OF DEATH

00227

|   |  |   |   |   |  |   |   |
|---|--|---|---|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>                |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>28 DAYS</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  |   |   | d. STREET ADDRESS<br><b>805 JEFFERIES STREET</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>VERNON</b> Middle <b>ROBERT</b> Last <b>CLARKE</b>  |  |   |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>1</b> Year <b>19 67</b>   |  |   |   |
| 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>WHITE</b>  |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JUNE 24, 1908</b>  |   |
| 9. AGE (n years last birthday)<br><b>58</b> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ser Sta Attendant</b> |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>                 |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |   | 13. FATHER'S NAME   |  |   |   |
| 14. MOTHER'S MAIDEN NAME  |  |   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>                              |  |   |   |
| 16. SOCIAL SECURITY NO.<br><b>217 07 62 71</b>  |  |   |   | 17. INFORMANT<br><b>CLINICAL RECORDS</b> Address <b>FORT HOWARD, MARYLAND</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>HEMORRHAGE FROM ESOPHAGEAL TRACHEA FISTULA</b><br>DUE TO (b) <b>CARCINOMA OF UPPER ESOPHAGUS</b><br>DUE TO (c) <b>UNKNOWN</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>MINUTES</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work               |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>DEC 7</b> , 19 <b>66</b> , to <b>JAN 4</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>JAN 4</b> , 19 <b>67</b> , and that death occurred at <b>800P M.</b> from causes and on the date stated above.   |  |   |   |   |  |   |   |
| 22a. SIGNATURE<br><i>Milton Ginsberg</i>  |  |   |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>1/5/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MILTON GINSBERG, M. D.</b>   |  |   |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>1/9/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE ANATIONAL</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |   |
| 24. FUNERAL DIRECTOR  |  |   |   | 25a. REC'D BY REGISTRAR<br><b>MC CULLY FUNERAL HOME</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |
| 25c. DATE<br><b>JAN 6 1967</b>  |  |   |   | 25d. ADDRESS<br><b>FORT AVENUE, BALTIMORE, MD.</b>  |  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b><br/> <b>CERTIFICATE OF DEATH</b> </div>   |  |  |  |  |  |   |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b> <u>Baltimore</u><br><b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br><b>c. LENGTH OF STAY</b> in <u>11 days</u><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>  |  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br><b>a. STATE</b> <u>Maryland</u> <b>b. COUNTY</b> <u>Baltimore</u><br><b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) <u>400 Murdock Road</u><br><b>d. STREET ADDRESS</b> <u>Baltimore Maryland</u><br><b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>Anna</u> <b>First</b> <u>N.M.N.</u> <b>Middle</b> <u>Collins</u> <b>Last</b><br><b>4. DATE OF DEATH</b> <u>1</u> <b>Month</b> <u>25</u> <b>Day</b> <u>1967</u> <b>Year</b>  |  |  |  |  |  | <b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>Cauc</u> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>9/18/85</u> <b>9. AGE</b> (In years last birthday) <u>81</u> <b>IF FUNER 1 YEAR</b> <u>81</u> <b>IF FUNER 24 HRS.</b> <u>81</u><br><b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Baltimore Md.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u> |  |  |  |  |  |
| <b>13. FATHER'S NAME</b> <u>Patrick Kennedy</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Kennedy</u>   |  |  |  |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u></u> <b>16. SOCIAL SECURITY NO.</b> <u>218-54-34</u> <b>INFORMANT</b> <u>Mrs. Charles Heinmuller</u> <b>Address</b> <u>400 Murdock Rd.</u>  |  |  |  |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <u>Cardiorespiratory failure</u><br><b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b><br><b>DUE TO (b)</b> <u>Cerebral vascular accident + Bronchopneumonia</u><br><b>DUE TO (c)</b> <u>Generalized arteriosclerosis.</u><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u></u> |  |  |  |  |  |   |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |   |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> <u>While at work</u> <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u></u> <b>20f. (City or town)</b> (County) (State) <u></u>  |  |  |  |  |  |   |  |  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>January 23, 1967</u> to <u>January 25, 1967</u>, that (I) (we) last saw the deceased alive on <u>January 24, 1967</u>, and that death occurred at <u>9:10 AM</u>, from the causes and on the date stated above.</b>   |  |  |  |  |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b> <u>Juan L. Roque</u> <b>22b. DATE SIGNED</b> <u>1/25/67</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>JUAN L. ROQUE</u> <b>22d. ADDRESS</b> <u>6701 N. Charles St. Balto 21204 MD.</u>  |  |  |  |  |  |   |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>1/28/67</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Cathedral Cem.</u> <b>23d. LOCATION</b> (City, town or county) (State) <u>Baltimore, Maryland</u>   |  |  |  |  |  |   |  |  |  |  |  |
| <b>24. FUNERAL DIRECTOR</b> <u>Mitchell-Wiedefeld Home</u> <b>ADDRESS</b> <u>6500 York Rd. Balto., Md. 21212</u> <b>25a. REC'D BY REGISTRAR</b> <u>JAN 28 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles</u>   |  |  |  |  |  |   |  |  |  |  |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00227

## CERTIFICATE OF DEATH

00229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>              |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>  |   | c LENGTH OF STAY IN 1b<br><b>Baltimore, 21234</b>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |   | d STREET ADDRESS<br><b>8219 Wilson Ave.</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Vaslan</b> Middle <b>B.</b> Last <b>Colwell</b>   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>13</b> Year <b>1967</b>   |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>4/30/15</b>   |
| 9 AGE (In years last birthday) yrs <b>51</b>   |   | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>13</b>  | IF UNDER 24 HRS<br>Hours <b>13</b> Min <b>67</b>  |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Splicer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>C. &amp; P. Tel. Co.</b>   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                         |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13 FATHER'S NAME<br><b>Joseph B. Colwell</b>   |   |
| 14 MOTHER'S MAIDEN NAME<br><b>Bessie G. Lent</b>   |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war and dates of service)<br><b>Yes</b>                                    |   |
| 16 SOCIAL SECURITY NO.<br><b>216-01-6917</b>   |   | 17 INFORMANT<br><b>Mrs. Valeria G. Thomas</b> Address <b>(Same)</b>  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary thrombosis, acute.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>4x20.1</b><br>DUE TO (c)                                |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>1) Severe arteriosclerosis of coronary arteries 2) pulmonary edema</b>   |   |  | 19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 13</b> , 1967, to <b>Jan. 13</b> , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 13</b> , 1967, and that death occurred at <b>9:30 PM</b> , from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br><b>Reynaldo Orjuela-Gomez, M.D.</b>  |   | 22b. DATE SIGNED<br><b>January 14, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Road, Baltimore, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/17/67.</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                        |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DATE Jan 18 1967</b>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00228 CERTIFICATE OF DEATH 00230

|  |  |   |  |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leatosville</u><br>c. LENGTH OF STAY IN b <u>5 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Forest Haven Nursing Home</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u><br>b. COUNTY <u>MD.</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>121 S. Schroeder St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Joseph</u> Middle <u>Emory</u> Last <u>Emory</u>   |  | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>1st</u> Year <u>1967</u>                                      |  | 9. AGE (In years last birthday) <u>76</u> yrs.   |  | IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u>                         |  | IF UNDER 24 HRS.<br>Hours <u>  </u> Min. <u>  </u>   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <u>3/28/96</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Pa.</u>                                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>miner</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>lignite mines</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |  |  |  |  |
| 13. FATHER'S NAME <u>Unknown</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give year or dates of service) <u>WW I</u>   |  | 16. SOCIAL SECURITY NO. <u>-P</u>   |  | 17. INFORMANT <u>Mrs Janet Lewis</u>   |  | Address <u>121 S Schroeder St</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>(a) IMMEDIATE CAUSE (a) <u>PULMONARY EMPHYSEMA + ASBESTOSIS</u><br><u>260X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>CHRONIC SEVERE CORONARY ARTERIO-SCLEROTIC DISEASE</u><br>DUE TO (c) <u>MYOCARDIAL INFARCTION - PULMONARY EMPHYSEMA</u> |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/1/1966</u> to <u>1/1/1967</u> , that (I) (we) last saw the deceased alive on <u>1/1/1967</u> , and that death occurred at <u>1:30 PM</u> , from the causes and on the date stated above.  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>John H. Shaw</u>   |  |   |  | 22b. DATE SIGNED <u>1/4/67</u>   |  | 22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw</u>                           |  |  |  |
| 22d. ADDRESS <u>5801 Edmondson Ave. Baltimore, Md.</u>   |  |   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1/5/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>  |  | 23d. LOCATION (City, town or county) (State) <u>5501 Madenbach Ave Md.</u> |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Gorman</u>   |  |   |  | ADDRESS <u>23 Hollins St. 23, Md.</u>  |  | 25a. REC'D BY REGISTRAR <u>Jan 4 1967</u>                                  |  | 25b. REGISTRAR'S SIGNATURE <u>John J. Gorman</u>   |  |





00229

CERTIFICATE OF DEATH

00231

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Towson</b> <b>BALTIMORE</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN lb<br><b>Baltimore</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital, 7620 York Rd. #2120</b>   |                                  | d. STREET ADDRESS<br><b>8418 Belair Road</b>  |   |
| 3. NAME OF DECEASED (Type of print)<br><b>SISTER M. OCTAVIA CONROY</b>  |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>19</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-15-1887</b>  |
| 9. AGE (In years last birthday)<br><b>79</b> yrs  |                                  | 10. F. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 24 HRS. <input type="checkbox"/>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Religious</b>   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Philadelphia, Penna.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph Conroy</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Kearney</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>Sister Catherine Rita</b>  |   |
| 17. INFORMANT<br><b>(Same)</b>  |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute.</b><br>DUE TO<br>(b) <b>Arteriosclerotic heart disease.</b><br>DUE TO<br>(c) <b>Coronary thrombosis, right.</b>                  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town)   |                                  | (County) (State)  |   |
| 21. I certify that (I) (the hospital) attended the deceased from <b>12-27-66</b> , 19 <b>67</b> , to <b>1-19</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1-19-67</b> , 19 <b>67</b> , and that death occurred at <b>4:35 PM</b> , from causes and on the date stated above |                                  |   |   |
| 22a. SIGNATURE<br><b>Arturo A. Pidlaoan M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>1-19-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Arturo Pidlaoan, M.D.</b>  |                                  | 22d. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1/23/67.</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00230

CERTIFICATE OF DEATH

00232

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE - Dundalk</b> |  |
| c. LENGTH OF STAY IN 1b <b>32 DAYS</b>  |  | d. STREET ADDRESS <b>8053 DELHAVEN ROAD</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print) First Middle Last <b>FRED -- COOPER Sr.</b>  |  | 4. DATE OF DEATH Month Day Year <b>JANUARY 31 1967</b>  |  |
| 5 SEX <b>MALE</b>   | 6 COLOR OR RACE <b>WHITE</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>MAY 17, 1894</b>                                     |
| 9 AGE (In years last birthday) <b>72</b> yrs  |  | 10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.  |  |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired, Watchman</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Co.</b>   |  |
| 11 BIRTHPLACE (County & State, or foreign country) <b>WOLF COUNTY, KENTUCKY</b>   |  | 12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>ALFRED F. COOPER</b>   |  | 14. MOTHER'S MAIDEN NAME <b>SARABELLE ROBERTS</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW-1</b>  |  | 16 SOCIAL SECURITY NO. <b>401 28 91 63</b>  |  |
| 17 INFORMANT <b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LIVER</b><br>1561<br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____ |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>BRONCHOPNEUMONIA. ARTERIOSCLEROTIC HEART DISEASE</b>  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Dec. 30, 1966</b> to <b>Jan. 31, 1967</b> that <del>he</del> (we) last saw the deceased alive on <b>Jan. 31, 1967</b> , and that death occurred at <b>1:15 a.m.</b> from causes and on the date stated above.                          |  |   |  |
| 22a. SIGNATURE <i>J. D. Talbert</i>   |  | 22b. DATE SIGNED <b>1/31/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>  |  | 22d. ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   | 23b. DATE THEREOF <b>2/3/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>  | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR <b>John J. Duda</b>  |  | 25a. REC'D BY REGISTRAR <b>FEB 1 1967</b>   |  |
| ADDRESS <b>7922 WISE AVENUE, BALTIMORE, MD.</b>   |  | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00231

## CERTIFICATE OF DEATH

00233

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <b>MARYLAND</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u><br>c. LENGTH OF STAY IN 1b <u>few months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bloombury Retreat, 200 Bloombury Ave.</u>  |  |   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>8346 Ridgely Oak Road</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First Middle Last<br><u>Lillie W. Coursey</u>  |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>Jan. 5, 1967</u>  |  | <b>5. SEX</b><br><u>Female</u>   |  |  |  |
| <b>6. COLOR OR RACE</b><br><u>White</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>Nov. 14, 1880</u>  |  |  |  |
| <b>9. AGE</b> (In years last birthday) <u>86 yrs.</u>  |  | <b>IF UNDER 1 YEAR</b><br>Months Days Hours Min.<br>_____   |  | <b>IF UNDER 24 HRS.</b><br>Hours Min.<br>_____   |  |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Domestic</u>   |  | <b>11. BIRTHPLACE</b> (County & State or foreign country)<br><u>Maryland</u>   |  |  |  |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  | <b>13. FATHER'S NAME</b><br><u>UNKNOWN</u>  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>UNKNOWN</u>  |  |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)<br><u>No</u>   |  | <b>16. SOCIAL SECURITY NO.</b><br><u>217-05-9642A</u>   |  | <b>17. INFORMANT</b><br><u>Madge V. Duvall (Daughter)</u> Same Address   |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC C V DISEASE</u><br>DUE TO (b) <u>CHRONIC ARTERIO SCLEROSIS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>VIRUS INFLUENZA</u> <u>CHRONIC COLITIS</u> |  |   |  |  |  |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br>OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____  |  |   |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____  |  |  |  |
| <b>20f. (City or town)</b> _____   |  | <b>(County)</b> _____   |  | <b>(State)</b> _____   |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>AUG 5, 1966</u> <b>to</b> <u>NOV 5, 1967</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1414 5-1967</u> <b>and that death occurred at</b> <u>5</u> <b>M.</b> <b>from the causes and on the date stated above.</b>  |  |   |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Paul R. Ziegler</u>  |  | <b>22b. DATE SIGNED</b><br><u>1967</u>  |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>PAUL R. ZIEGLER</u>  |  |  |  |
| <b>22d. ADDRESS</b><br><u>200 WEST 11th St. BALTIMORE, MD.</u>   |  | <b>22e. REC'D BY REGISTRAR</b>  |  | <b>22f. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  | <b>23b. DATE THEREOF</b><br><u>Jan. 9, 1967</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Lorraine Park Cemetery</u>   |  |  |  |
| <b>23d. LOCATION (City, town or county)</b><br><u>Baltimore, Md.</u>   |  | <b>23e. REC'D BY REGISTRAR</b>  |  | <b>23f. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Eugenia K. Seitz</u> <b>ADDRESS</b> <u>5209 York Road</u><br><u>Seitz Funeral Home</u> <u>Balto, Md. 21212</u>   |  |   |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

DATE

JAN 10 1967

[Signature]



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

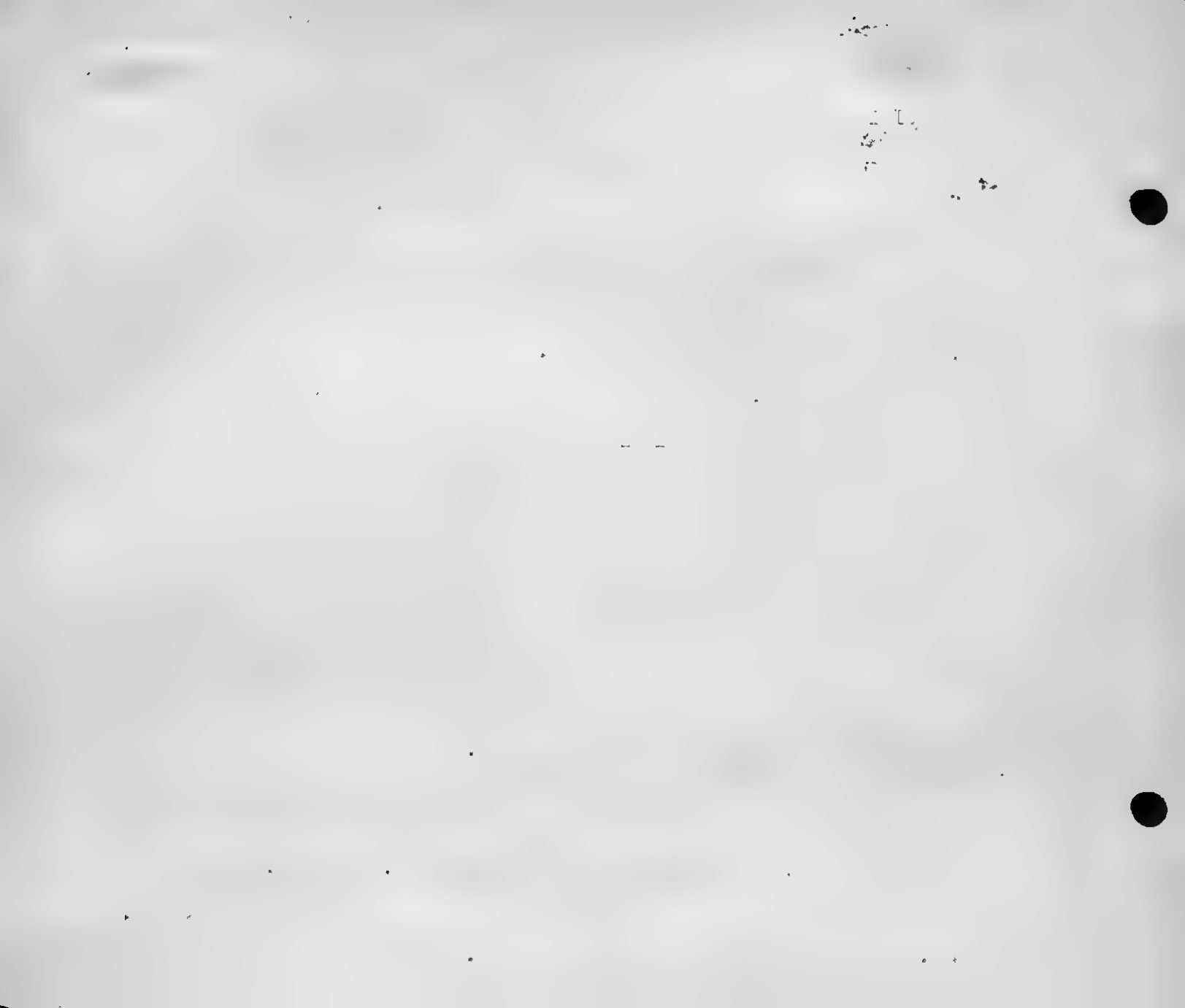
00232

00234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>COUNTY<br><b>Baltimore</b><br>CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <b>Md</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>3501 St. Paul Street</b> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Mary Agnes Coyne</b>   |   | 4. DATE OF DEATH<br>Month <b>1</b> / Day <b>19</b> / Year <b>67</b>  |   |
| 5. SEX<br><b>F</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>% 5/9/1888</b>                                 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dir. of Claims Statistics Veterans Adm.</b>  |   | 9b. AGE (In years last birthday)<br><b>78</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dir. of Claims Statistics Veterans Adm.</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>George W Wilkinson</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Susan Winters</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>215-32-8392</b>  |   |
| 17. INFORMANT<br><b>Hospice records</b>   |   | Address  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br><b>Respiratory Failure</b><br><b>Cerebral vascular Hemorrhage</b><br><b>ASCD</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 17, 1967</b> to <b>Jan. 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 18, 1967</b> , and that death occurred at <b>5:50 A.M.</b> from the causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><b>Robert J. Mahoney</b>  |   | 22b. DATE SIGNED<br><b>1/19/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Robert J. Mahoney, M.D.</b>  |   | 22d. ADDRESS<br><b>201 E. Joppa Rd., Towson</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1/21/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>CATHEDRAL</b>   | 23d. LOCATION (City, town or county) (State)<br><b>BALTIMORE, MD.</b> |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H.W. MEARS &amp; SON</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 24 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |   |

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00233

## CERTIFICATE OF DEATH

00235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>20yr8mth3dys.</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lula</b> Middle <b>Crane</b> Last <b>Crane</b>  |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>4</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Feb. 10, 1906</b> |
| 9. AGE (In years last birthday) yrs.<br><b>60</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>North Carolina</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  |
| 13. FATHER'S NAME<br><b>W.H. Wagner</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Disia Greene</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br><b>Bronchopneumonia</b><br>IMMEDIATE CAUSE (a) <b>471A</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>May 1, 1965</b> to <b>Jan. 4, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 4, 1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.   |                                  |   |  |
| 22a. SIGNATURE<br><i>Anthony J. Young</i> M.D.  |                                  | 22b. DATE SIGNED<br><b>1-4-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>   |                                  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Removal</b>   |                                  | 23b. DATE THEREOF<br><b>1-5-67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Fernwood Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Delaware Co. Pa.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Tibner &amp; Son</b>  |                                  | 25. REC'D BY REGISTRAR<br><b>Baltimore, Md. north, Pa.</b>  |  |
| 26. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                  | DATE <b>JAN 6 1967</b>  |  |



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

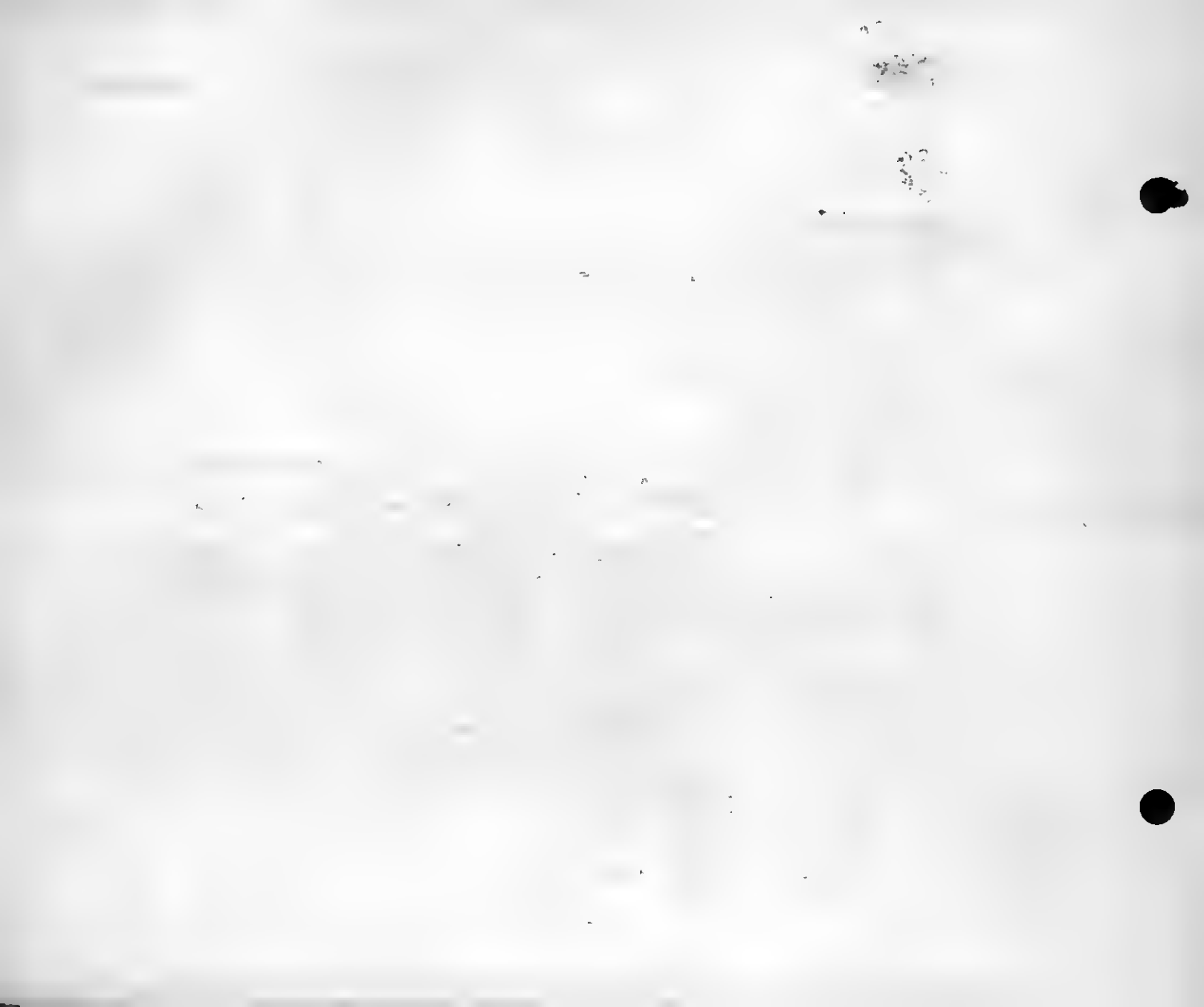
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                           |  |   |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND   |                           | 2. USUAL RESIDENCE (Where deceased lived, if inst lnt on Res. before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO</b>                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>EDGEMERE</b>   |                           | c. LENGTH OF STAY IN TB  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2510 SNIDER AVE</b>  |                           | e. STREET ADDRESS<br><b>7929 ECHOH</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>LOUISE E. CRIKENBERGER</b>  |                           | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>18</b> Year <b>1967</b>  |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>APR. 4, 1917</b> |
| 9. AGE (In years last birthday) <b>49</b> yes   |                           | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>18</b> Hours <b>19</b> Min <b>67</b>  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>FLA.</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>   |   |
| 13. FATHER'S NAME<br><b>PETER EWING</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>ANN ALLSEBROOK</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                           | 16. SOCIAL SECURITY NO<br><b>213-38-4934</b>   |   |
| 17. INFORMANT<br><b>EARL C. CRIKENBERGER</b>  |                           | Address<br><b>ABOVE</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>525X</b><br>IMMEDIATE CAUSE (a) <b>Acute Pulmonary Failure</b><br>DUE TO (b) <b>Chronic Inflammatory disease</b><br>DUE TO (c) <b>of Lung Etiology Undetermined</b>   |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>8-10 mos</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>pm</b> <b>19</b>  |                           | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |  |   |
| ACTUAL SIGNATURE<br><b>THEO. C. PATERSON</b>  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>THEO. C. PATERSON</b>  |                           | ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>  |   |
|   |                           | DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>  |   |
|   |                           | Address (Street, city, town or county)   |   |
| 22. DATE SIGNED<br><b>1/20/67</b>   |                           |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                           | 23b. DATE THEREOF<br><b>1/21/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>CAK LAWN</b>   |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>J.E. CONNELLY SONS</b>   |                           | ADDRESS<br><b>300 MACE</b>   |   |
| 25a. RECD BY REGISTRAR<br><b>JAN 24 1967</b>  |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



00235

## CERTIFICATE OF DEATH

00237

|  |                              |  |   |  |  |  |                              |
|--|------------------------------|--|---|--|--|--|------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                              |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Ohio</b> b. COUNTY              |  |  |                              |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lutherville</b>   |                              |  |   | c. LENGTH OF STAY IN 1b  |  |  |                              |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>College Manor, Seminary Ave.</b>  |                              |  |   | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Shaker Heights</b>                            |  |  |                              |
| f. STREET ADDRESS<br><b>N. Moreland Blvd.</b>  |                              |  |   | g. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                    |  |  |                              |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Florence Anderson Cross</b>  |                              |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>January 6th., 1967</b>  |  |  |                              |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>August 6, 1882</b> |  | 9. AGE (In years last birthday) yrs<br><b>84</b> | IF UNDER 1 YEAR<br>Months Days Hours Min   | IF UNDER 24 HRS<br>Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (County & State or foreign country)<br><b>Midland, Michigan</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                              |
| 13. FATHER'S NAME<br><b>Fred S. Anderson</b>   |                              |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Addie Sophia Moore</b>  |  |  |                              |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                              | 16. SOCIAL SECURITY NO.<br><b>100-40-8296</b>  |   | 17. INFORMANT<br>Address <b>Bank Bldg.</b><br><b>Frederic S. Cross, 900 1st Nat'l</b>  |  |  |                              |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>450.0 congestive heart failure</b><br>DUE TO (b) <b>arteriosclerosis, generalized</b><br>DUE TO (c) <b>10 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                              |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>                                    |                              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |  |   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |                              |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |  |                              |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |                              |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 1962</b> to <b>1/6</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/4</b> , 19 <b>67</b> , and that death occurred at <b>8:30 PM</b> from causes and on the date stated above.  |                              |  |   |  |  |  |                              |
| 22a. SIGNATURE<br><b>William F. Fritz</b>  |                              |  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/6/67</b>  |                              |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. William F. Fritz</b>  |                              |  |   | 22d. ADDRESS<br><b>2 W. University Parkway</b>   |  |  |                              |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Rem. burial</b>  |                              | 23b. DATE THEREOF<br><b>1/7/1967</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Knollwood</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Mayfield Heights, Ohio</b>         |                              |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</b>  |                              |  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 9 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>William F. Fritz</b>                                  |                              |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (57)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 23 Film G-84 1/12/67 mh

00238

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00238

|   |                                 |  |   |  |  |
|---|---------------------------------|--|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution on residence before admission)<br>a. STATE<br><b>Maryland</b>  |   | b. COUNTY<br><b>Baltimore</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>   |                                 | c. LENGTH OF STAY IN IB  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph's Hospital</b>  |                                 |  |   | d. STREET ADDRESS<br><b>1001 Reverdy Road</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>PATRICIA ANN CROWTHER</b>   |                                 | 4 DATE OF DEATH<br>Month <b>1</b> Day <b>10</b> Year <b>1967</b>   |   |  |  |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                        | 8 DATE OF BIRTH<br><b>June 30, 1936</b> | 9 AGE (In years lost birthday)<br><b>30 yrs</b>  | IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>                 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Artist</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Department Store</b>   |   | 11 BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                                    |  |
| 13 FATHER'S NAME<br><b>Robert L. Crowther</b>   |                                 | 14 MOTHER'S MAIDEN NAME<br><b>Katheryn Wood</b>  |   | 2 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                 | 16 SOCIAL SECURITY NO<br><b>212-34-4293</b>  |   | 17 INFORMANT<br><b>Robert L. Wood (Father)</b> Address <b>Same</b>                                   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>812.4</b> IMMEDIATE CAUSE (a) <b>Multiple Traumatic Injuries</b><br>DUE TO<br>(b) _____<br>DUE TO<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |                                 |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                 |  |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item B)<br><b>Pedestrian struck by auto. Belvedere &amp; Gilpin Ave.</b>                     |   |  |  |
| 20c. TIME OF INJURY Month Day Year<br>Hour a.m. <b>PM</b> <b>1 11 19 67</b>   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, off campus, etc.)<br><b>Street Baltimore Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                 |  |   |  |  |
| ACTUAL SIGNATURE<br><b>Rudiger Breitenecker, M.D.</b>   |                                 | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | 22. DATE SIGNED<br><b>1/11/67</b>  |  |
| EXAMINER'S NAME (Type)  |                                 | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>1/14/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>                                  |  |
| 24. FUNERAL DIRECTOR<br><b>Eugenia K. Seitz</b>   |                                 | ADDRESS<br><b>5209 York Road Balto. Md. 21212</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 13 1967</b>  |  |
|   |                                 |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in no event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |   |  |  |   |   |  |  |  |
|--|--|--|---|--|--|---|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201   |  |  |   |  |  |   |   |  |  |  |
| 00237  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH          |   |  |  | 00239                                   |   |  |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |  |   |  | 2 USUAL RESIDENCE (Where deceased lived, if inst. lft on a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> <input checked="" type="checkbox"/> Residence before adm. ssion |   |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |  |  | c. LENGTH OF STAY IN Tn<br><b>4 yrs.</b>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Balt.</b>   |   |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hosp.</b>   |  |  |   |  | d. STREET ADDRESS<br><b>40 E. Cross St.</b>  |   |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Doris</b> Middle <b>Mary</b> Last <b>Cumberland</b>   |  |  |   |  | 4 DATE OF DEATH<br>Month <b>Jan.</b> Day <b>1</b> Year <b>67</b>   |   |   |  |  |  |
| 5 SEX<br><b>F</b>  |  | 6 COLOR OR RACE<br><b>W</b>                      |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8 DATE OF BIRTH<br><b>Dec. 18, 1924</b> |   | 9 AGE (In years last birthday) <b>42</b> yrs   |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>None</b> |   | 11 BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                     |  |  |  |
| 3 FATHER'S NAME<br><b>Charles Roger Cumberland</b>   |  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Rose Catherine Ubell</b>  |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  | 16 SOCIAL SECURITY NO<br><b>none</b>  |  | 17 INFORMANT<br><b>Records-Rosewood State Hosp. Owings Mills, Md.</b>  |   |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>asphyxia (Due to aspiration of food)</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>7.11.1</b><br>(b) <b>mental Retardation (Imbecile)</b><br>(c) <b>None</b>  |  |  |   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2.5 max.</b>  |  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>None</b>   |  |  |   |  |  |   |   | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)<br><b>Patient rammed food in mouth + choked</b>               |  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>12:15</b> pm <b>1-1</b> 19 <b>67</b>   |  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street off ca. bldg, etc.)<br><b>Rosewood Hosp</b>  |   | 20f. (City or town) <b>Owings Mills</b> (County) <b>Calh</b> (State) <b>Ind</b> |  |  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |  |  |   |   |  |  |  |
| ACTUAL SIGNATURE <b>D. D. Catles</b> M.D.  |  |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |  |  |
| EXAMINER'S NAME (Type) <b>D. D. CATLES</b>   |  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |   |  |  |  |
|  |  |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |   |  |  |  |
|  |  |  |   |  | Address (Street, city, town, or county)  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  | 23b. DATE THEREOF<br><b>1 4 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill</b>  |   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Brooklyn, A. A. Co. Md.</b>                |  |  |
| 24 FUNERAL DIRECTOR<br><b>Mc Cully</b>   |  |  |   |  | ADDRESS<br><b>130 E. Fort Ave</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1967</b>                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b> |  |



CERTIFICATE OF DEATH

00238

00240

Item 2 1711 0005 2/10/67

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b><br>c. LENGTH OF STAY IN TB <b>Months</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Stella Maris Hospice</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>1209 Valley St. 1877 Munsey Bldg</b> |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>Margaret Cunningham</b><br>First Middle Last   |  |  |  | 4. DATE OF DEATH <b>Jan. 26, 1967</b><br>Day Year   |  |   |  |
| 5. SEX <b>F</b>   |  | 6. COLOR OR RACE <b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>1/27/1872</b>   |  |
| 9. AGE (In years last birthday) <b>94</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse Maid</b> |  | 11. BIRTHPLACE (County & State, or foreign country) <b>Rosecommon, Ireland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>                                       |  |
| 13. FATHER'S NAME <b>James A. Cunningham</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Bridgett Boland</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  | 16. SOCIAL SECURITY NO. <b>212-32-1200</b>   |  | 17. INFORMANT <b>Hospice records</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Expiratory Arrest</b><br>DUE TO <b>ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Serious</b><br>(b) <b>Serious</b><br>(c) <b>Serious</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19, 1954</b> to <b>1/27/67</b> , 19... , that (I) (we) last saw the deceased alive on <b>1/24/67</b> ..19....., and that death occurred at <b>2:00 PM</b> from the causes and on the date stated above.   |  |  |  |   |  |   |  |
| 22a. SIGNATURE <b>Robert J. Mahon, MD</b>   |  |  |  | 22b. DATE SIGNED <b>1/26/67</b>   |  | 22c. PHYSICIAN'S NAME (Type) <b>Robert J. Mahon, MD</b>                       |  |
| 22d. ADDRESS <b>204 E. Joppa Rd., Towson</b>  |  |  |  | 22e. REC'D BY REGISTRAR <b>1/26/67</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>1-28-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>   |  | 23d. LOCATION (City, town or county) (State) <b>Baltimore, Baltimore, Md.</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Brooks Towson, Towson, Md. 21204</b>   |  |  |  |   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

JAN 30 1967



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00239

## CERTIFICATE OF DEATH

00241

|   |  |  |  |
|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>--</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>23yr6nth29dys</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>3921 Yolando Road</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Annie Curry</b>  |  | 4. DATE OF DEATH Month Day Year<br><b>January 31 19 67</b>   |  |
| 5. SEX<br><b>female</b>   | 6. COLOR OR RACE<br><b>white</b>       | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH<br><b>Sept. 6, 1877</b>   |
| 9. AGE (In years past birthday) yrs<br><b>89</b>  |  | 10. UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (County & State or foreign country)<br><b>Maryland</b>                                |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>  |  | 13. FATHER'S NAME<br><b>Frank Kohler</b>   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Kunigunda</b>  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  |
| 16. SOCIAL SECURITY NO<br><b>219-54-3083</b>  |  | 17. INFORMANT Address<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (b) <b>Generalized arteriosclerosis</b><br>DUE TO (c) <b>422.1</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town) (County) (State)  |  | 21. I certify that (this hospital) attended the deceased from <b>July 2, 1943</b> to <b>Jan. 31, 1967</b> , that (we) last saw the deceased alive on <b>Jan. 31, 1967</b> and that death occurred at <b>2:00 p.m.</b> , from causes and on the date stated above |  |
| 22a. SIGNATURE<br><b>Stella Wachslar</b>  |  | 22b. DATE SIGNED<br><b>2-1-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>  |  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>FEB 3 1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NEW CATHEDRAL CEM</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>OLD FREDERICK RD MD</b>                          |
| 24. FUNERAL DIRECTOR<br><b>Duffel Bros Inc. 1800 E LOMBARD ST</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE FEB 3 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
 20M 5-63

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |  |  |  |  |  |  |
|---|--|----------------------------------|--|---|--|--|--|--|--|--|--|
| 00240 CERTIFICATE OF DEATH 00242  |  |                                  |  |   |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Rural - Baltimore Highlands</b>  |  |                                  |  |   |  | c. LENGTH OF STAY IN 15<br><b>48 years</b>   |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>2926 Ohio Avenue</b>   |  |                                  |  |   |  | d. STREET ADDRESS<br><b>2927 Georgia Avenue</b>  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Helen M. Dallas</b>  |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 30th, 1967</b>  |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>February 9, 1918</b>  |  | 9. AGE (in years last birthday)<br><b>48 yrs.</b>                      |  | IF UNDER 1 YEAR<br>Months Days<br><b>1 year</b>                            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Seamstress</b>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Howard Uniform Co.</b>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                            |  |
| 13. FATHER'S NAME<br><b>Louis Weber</b>   |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Wisniewski</b>  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>No</b>  |  |                                  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>218-01-8727</b>  |  |  |  |  |  |
| 17. INFORMANT<br><b>Walter T. Dallas - 2927 Georgia Avenue #21227</b>   |  |                                  |  |   |  | Address  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of colon</b><br><b>152</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) } DUE TO<br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  |   |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |  |   |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |                                  |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11 Feb 1967</b> to <b>30 Jan 1967</b> , that (I) (we) last saw the deceased alive on <b>26 Jan 1967</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.  |  |                                  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>W. K. Gallagher Jr.</b>  |  |                                  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22b. DATE SIGNED<br><b>30 Jan 67</b>                                   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher Jr. M.D.</b>   |  |                                  |  |   |  | 22d. ADDRESS<br><b>6630 BALTIMORE NAT. PIKE 21228</b>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  |  | 23b. DATE THEREOF<br><b>Feb. 2, 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>George A. Weber</b>  |  |                                  |  |   |  | ADDRESS<br><b>705 South Ann St. #21231</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 1 1967</b>                      |  | 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>                         |  |

MEDICAL CERTIFICATION





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00241

CERTIFICATE OF DEATH

00243

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE CO.</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE CITY</u>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RURAL CATONSVILLE</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE CITY</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>PRINC-GRACE STATE HOSP.</u>   |   | d. STREET ADDRESS<br><u>2221 WILKINSON ST.</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>LOUISA</u> First <u>DANIEL</u> Middle Last  |   | 4 DATE OF DEATH<br>Month <u>JAN.</u> Day <u>1</u> Year <u>1967</u>  |   |
| 5 SEX<br><u>F</u>  | 6 COLOR OR RACE<br><u>NEGR</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>4/30/79</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done dur ng most of working life, even if retired)<br><u>HOUSEWIFE</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NONE</u>  | 9 AGE (In years last birthday)<br><u>87</u> yrs.  |
| 11 BIRTHPLACE (County & State or foreign country)<br><u>NORTH CAROLINA</u>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |   |
| 13 FATHER'S NAME<br><u>WILLIS BOYD</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>RENNIE -</u>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO  |   |
| 17 INFORMANT<br><u>HOSPITAL RECORD</u>   |   | Address<br><u>SCS.H.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><u>493X</u> IMMEDIATE CAUSE (a) <u>PNEUMONIA</u><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____<br>DUE TO (b) _____<br>DUE TO (c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>NONE EXCEPT SENILITY</u>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-31</u> , 19 <u>65</u> , to <u>Jan. 1</u> , 19 <u>67</u> , that <u>XX</u> (we) last saw the deceased alive on <u>January 1</u> , 19 <u>67</u> , and that death occurred at <u>7:10AM</u> , from causes and on the date stated above.                          |   |   |   |
| 22a. SIGNATURE<br><u>Allen W. Lane</u>   |   | 22b. DATE SIGNED<br><u>January 1, 1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Allen W. Lane</u>   |   | 22d. ADDRESS<br><u>Spring Grove State Hospital</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>1/6/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Church Cem.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Grenville N.C.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>Geo. G. Kelson 1348 n. Calhoun st.</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 3 1967</u>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE  |   |



00242

## CERTIFICATE OF DEATH

00244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

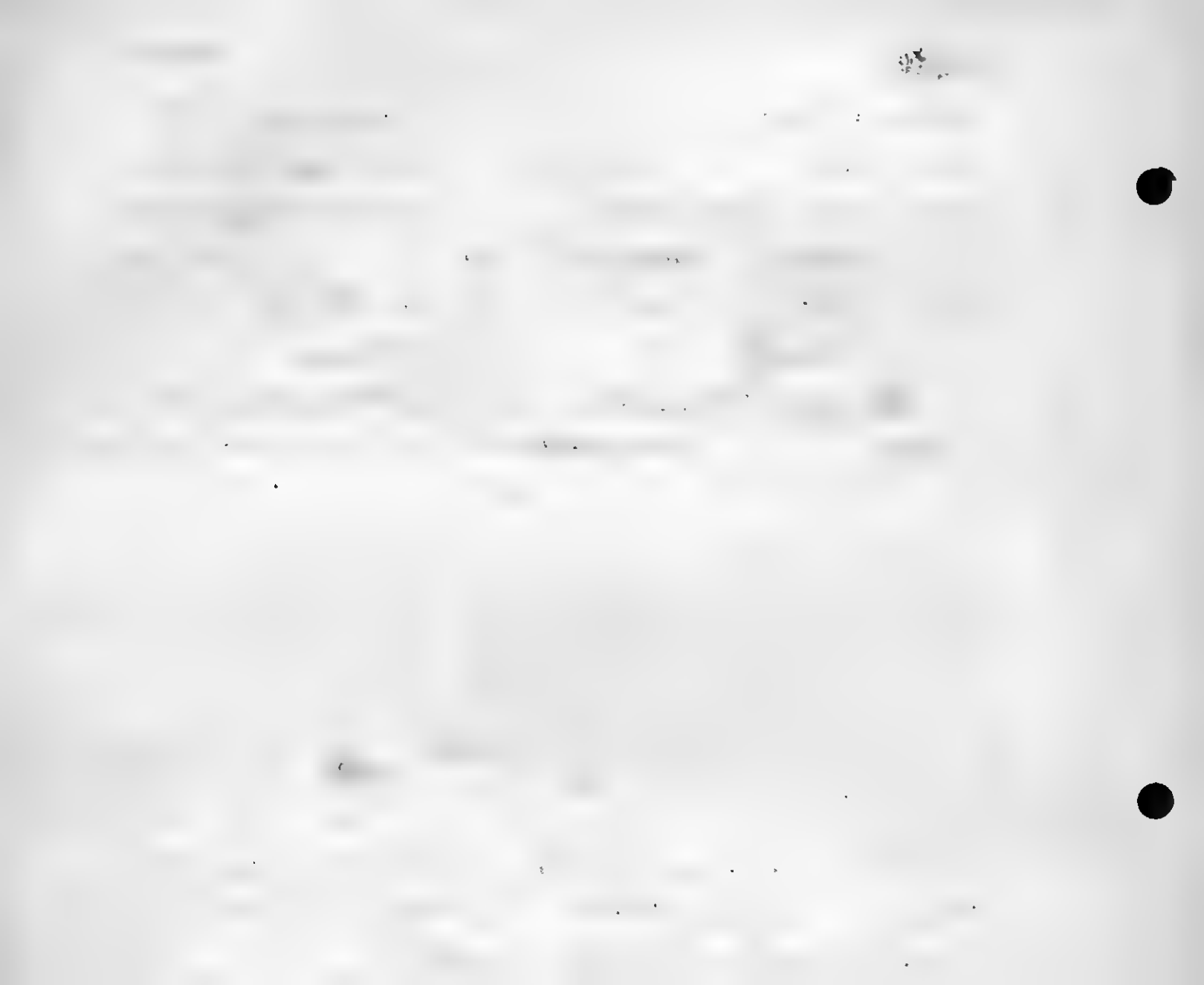
|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |   | c. LENGTH OF STAY IN 1b<br><b>4 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>2565 ARUNAH AVENUE</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>WILLIAM</b> Last <b>DAVIS</b>   |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>9</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>MAY 9, 1907</b>                                      |
| 9. AGE (in years last birthday) <b>59</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>JERSEY CITY, NEW JERSEY</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><i>Joseph Davis</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Julia Lambert</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |   | 16. SOCIAL SECURITY NO.<br><b>217 01 84 74</b>  |   |
| 17. INFORMATION<br><b>VA HOSPITAL</b>  |   | 18. CLINICAL RECORDS<br><b>FORT HOWARD, MARYLAND</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>UREMIA</b><br>DUE TO <b>CHRONIC PYELONEPHRITIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JAN 5</b> , 19 <b>67</b> , to <b>JAN 9</b> , 1967, that <input checked="" type="checkbox"/> (we) lost the deceased alive on <b>JAN 9</b> , 19 <b>67</b> , and that death occurred at <b>655 P.M.</b> , from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><i>J. D. Talbert</i>   |   | 22b. DATE SIGNED<br><b>1/10/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1-13-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR   |   | 25a. REC'D BY REGISTRAR<br><b>RAYNER SANDERS FUNERAL HOME</b><br>DATE <b>JAN 16 1967</b>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>1 (M)</p> <p>00243</p> </div> <div> <p>STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p>00245</p> </div> </div>  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|--|--|---|--|--|--|--|--|--|--|
| <p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Baltimore County</b> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Mount Wilson</b></p> <p>c. LENGTH OF STAY IN 1b <b>113 days</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Mount Wilson State Hospital</b></p>  |  |  |  |   |  | <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <b>Maryland</b> b. COUNTY <b>Balt. Co</b></p> <p>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Balt. md. 21222</b></p> <p>d. STREET ADDRESS <b>3416 McShane Way</b></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |  |  |  |  |  |
| <p>3. NAME OF DECEASED (Type or print) <b>Mary Campbell Davis</b></p>   |  |  | <p>4. DATE OF DEATH <b>Jan 12 1967</b></p> |   |  | <p>5. SEX <b>F</b></p>   |  |  | <p>6. COLOR OF RACE <b>W</b></p>   |  |  |
| <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>   |  |  | <p>8. DATE OF BIRTH <b>9-18-1891</b></p>   |   |  | <p>9. AGE (In years last birthday) <b>75</b> yrs.</p>  |  |  | <p>10. IF UNDER 1 YEAR Months Days Hours Min.</p>                            |  |  |
| <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.F.</b></p>  |  |  |  |   |  | <p>10b. KIND OF BUSINESS OR INDUSTRY</p>   |  |  | <p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>Penna.</b></p> |  |  |
| <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>13. FATHER'S NAME <b>George Campbell</b></p>   |  |  |  |   |  | <p>14. MOTHER'S MAIDEN NAME <b>Sarah Watson</b></p>  |  |  |  |  |  |
| <p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)</p>  |  |  |  |   |  | <p>16. SOCIAL SECURITY NO. <b>218-14-0449</b></p>  |  |  |  |  |  |
| <p>17. INFORMANT <b>Records, Mt. Wilson State Hospital</b></p>  |  |  |  |   |  | <p>Address</p>   |  |  |  |  |  |
| <p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1561 Reticulum Cell Sarcoma of Liver</b></p> <p>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</p> <p>DUE TO (b) _____</p> <p>DUE TO (c) _____</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b></p> |  |  |  |   |  |  |  |  |  |  |  |
| <p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b></p>  |  |  |  | <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> |  | <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>  |  | <p>20f. (City or town) (County) (State)</p>                              |  |  |  |
| <p>21. I certify that (I) (this hospital) attended the deceased from <b>9-21-</b>, 19<b>66</b>, to <b>1-12</b>, 19<b>67</b>, that (I) (we) last saw the deceased alive on <b>1-2</b>, 19<b>67</b>, and that death occurred at <b>12:30</b> P.M. from the causes and on the date stated above.</p>   |  |  |  |   |  |  |  |  |  |  |  |
| <p>22a. SIGNATURE <b>W. Newcomer</b></p>  |  |  |  |   |  |  |  | <p>22b. DATE SIGNED <b>1-12-67</b></p>                                   |  |  |  |
| <p>22c. PHYSICIAN'S NAME (Type) <b>Wm. Newcomer, M.D., Superintendent</b></p>   |  |  |  |   |  |  |  | <p>22d. ADDRESS <b>Mount Wilson, Maryland</b></p>                        |  |  |  |
| <p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>  |  |  |  | <p>23b. DATE THEREOF <b>1/16/67</b></p>   |  | <p>23c. NAME OF CEMETERY OR CREMATORY <b>BALTO. NATIONAL</b></p>   |  | <p>23d. LOCATION (City, town or county) (State) <b>BALTIMORE, MD</b></p> |  |  |  |
| <p>24. FUNERAL DIRECTOR <b>Wm. Newcomer</b></p>   |  |  |  |   |  |  |  | <p>25. REC'D BY REGISTRAR <b>Charles Judge</b></p>                       |  |  |  |
| <p>25. DATE <b>JAN 16 1967</b></p>  |  |  |  |   |  |  |  | <p>25b. REGISTRAR'S SIGNATURE</p>  |  |  |  |



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

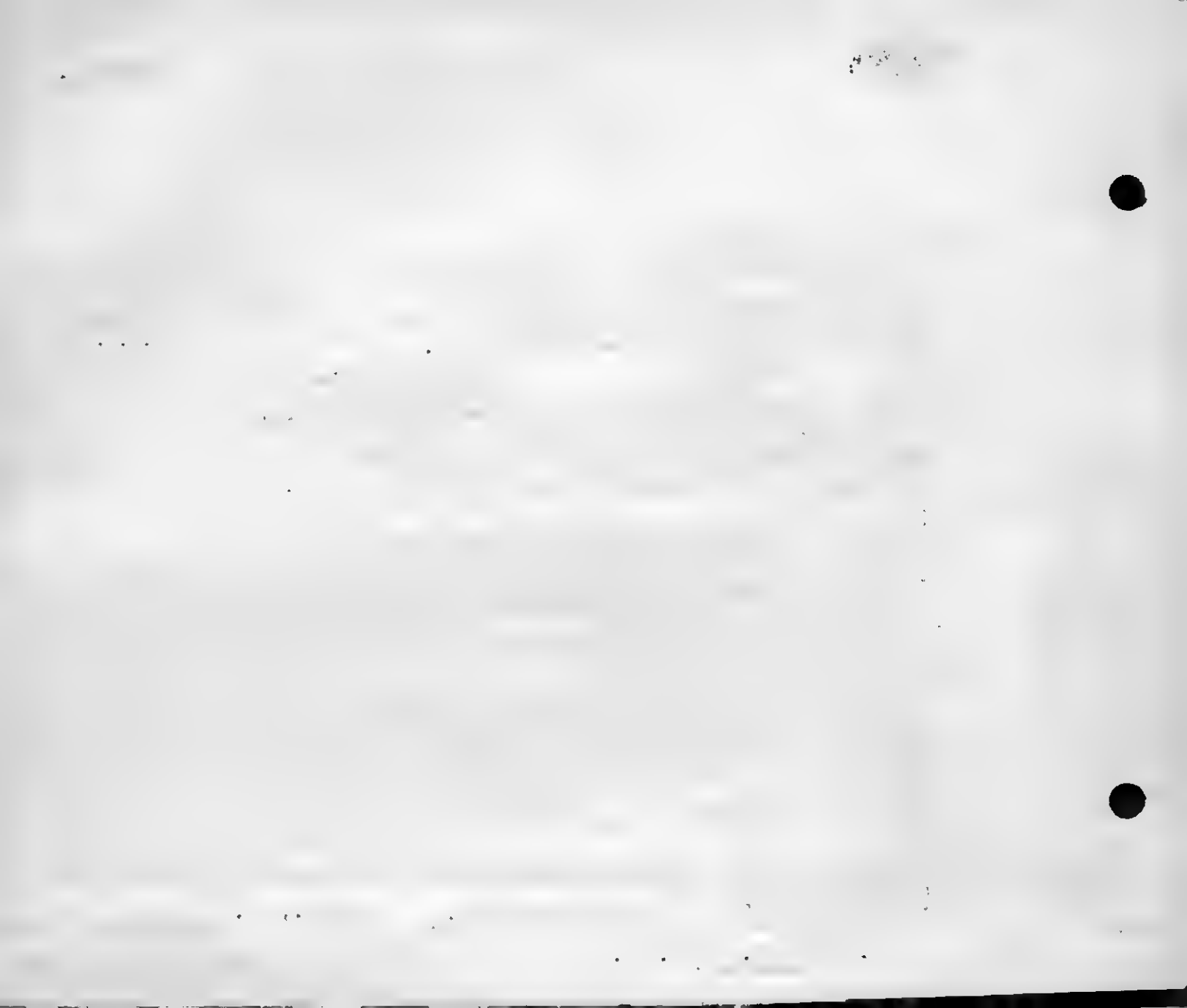
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00244

00246

|  |  |  |   |   |  |
|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u>  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore rural</u>                                   |   |  |
| c. LENGTH OF STAY IN TB <u>5 yrs.</u>  |  |  | d. STREET ADDRESS <u>1721 Aberdeen Rd</u>   |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1721 Aberdeen Rd</u>   |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |  |
| 3. NAME OF <u>(SAMUEL)</u> First Middle Last <u>SALVATORE Columbus Dell'Acqua</u>  |  |  | 4. DATE OF DEATH <u>Jan 5 1967</u>  |   |  |
| 5. SEX <u>MALE</u>   |  |  | 6. COLOR OR RACE <u>White</u>   |   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH <u>5-18-32</u>   |   |  |
| 9. AGE in years last birthday <u>35</u>  |  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAINTENANCE</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Loch Raven Village Md.</u>   |   |  |
| 11. BIRTHPLACE (State or foreign country)  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>  |   |  |
| 13. FATHER'S NAME <u>LUCIANO Dell'Acqua</u>  |  |  | 14. MOTHER'S MAIDEN NAME <u>Angela ONORATO</u>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war/dates of service) <u>1949-1952</u>   |  |  | 16. SOCIAL SECURITY NO. <u>214-26-6401</u>  |   |  |
| 17. INFORMANT <u>Anna Dell'Acqua</u>   |  |  | Address <u>same</u>   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Atherosclerosis Cardiac Vascular Disease &amp; Coronary Insufficiency of several yrs.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>same</u><br>DUE TO (c) <u>same</u>   |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>  |  |  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       | 20f. (City or town)   | (County)  | (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Nature <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |   |  |
| ACTUAL SIGNATURE <u>John C. Hyatt</u>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   | DATE SIGNED <u>Jan 5-67</u>                                 |  |
| EXAMINER'S NAME (Type) <u>JOHN C. Hyatt</u>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |  |
| Address (Street, city, town, or county)  |  |  |   |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 22b. DATE THEREOF <u>1/9/1967</u>  | 22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>                                 | 22d. LOCATION (City, town, or county) <u>Balto., Md.</u>  | (State)   |  |
| 23. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>  |  | ADDRESS  |   | 24a. REC'D BY REGISTRAR <u>JAN 10 1967</u>                  | 24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |





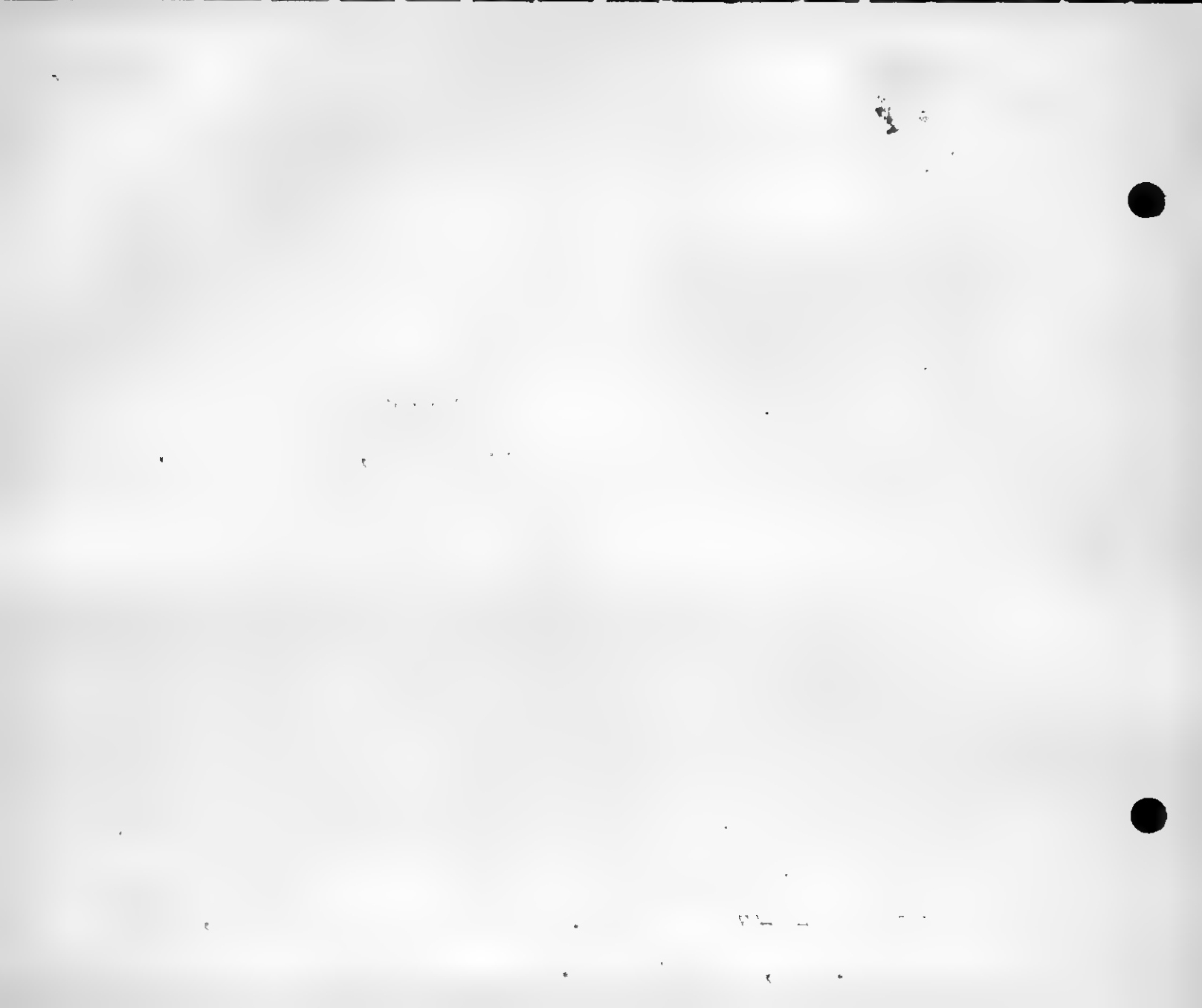
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b><br>c. LENGTH OF STAY IN b. <b>1 DAY</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>GREATER BALTIMORE MEDICAL CENTER</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>MARLEY NECK</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GLEN BURNIE</b><br>d. STREET ADDRESS <b>ROUTE 4 BOX 123A</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print) <b>DEMBY, MAY NEVELLA</b><br>First Middle Last<br>4. DATE OF DEATH <b>19 10 55 AM 1967</b><br>Month Day Year   |  | 5. SEX <b>FEMALE</b><br>6. COLOR OR RACE <b>NEGRO</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>5/13/07</b><br>9. AGE (In years last birthday) <b>59 yrs.</b><br>IF UNDER 1 YEAR Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b><br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE, MARYLAND</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  | 13. FATHER'S NAME <b>JAMES FRANKLIN</b><br>14. MOTHER'S MAIDEN NAME <b>Katherine Boose</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMY OR FORCES? (Yes, no, or unknown) <b>No</b><br>(If yes give war or dates of service)<br>16. SOCIAL SECURITY NO.<br>17. INFORMANT <b>Ernest Demby, 1275 Kitmore Rd.</b><br>Address  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRAIN ABSCESS</b><br>311<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>OTITIS MEDIA</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS WITH RENAL FAILURE</b> |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that (I) (this hospital) attended the deceased from <b>January 18, 1967</b> to <b>January 19, 1967</b> , that (I) (we) last saw the deceased alive on <b>January 19, 1967</b> , and that death occurred at <b>10<sup>55</sup> AM</b> , from the causes and on the date stated above.<br>22a. SIGNATURE <b>Dewilsky</b><br>22b. DATE SIGNED <b>1-19-67</b><br>22c. PHYSICIAN'S NAME (Type) <b>Dora C. Dewilsky</b><br>22d. ADDRESS <b>Greater Baltimore Medical Center</b>         |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b><br>23b. DATE THEREOF <b>1-23-67</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary</b><br>23d. LOCATION (City, town or county) (State) <b>Baltimore, Maryland</b>  |  | 24. FUNERAL DIRECTOR <b>Charles R. Law, 802 Madison Ave.</b><br>ADDRESS<br>25a. REC'D BY REGISTRAR <b>JAN 23 1967</b><br>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |

MEDICAL CERTIFICATION



00246

## CERTIFICATE OF DEATH

00248

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN TB<br><b>121</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>             |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore - 21221</b><br>d. STREET ADDRESS<br><b>10 Marie Avenue</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Lerew William Detter</b>  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>15</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>April 6, 1914</b><br>9. AGE (n years last birthday) yrs. <b>52</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Fidelity Ship Ceiling</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore</b>  |   |
| 13. FATHER'S NAME<br><b>GEO. DETTER</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NAK</b>   |   | 16. SOCIAL SECURITY NO<br><b>189-07-2686</b>   |   |
| 17. INFORMANT<br><b>MYRTLE DETTER</b>  |   | Address<br><b>10 MARIE AVE</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Terminal carcinomatosis, primary site undetermined.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____<br>DUE TO (c) _____ |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>1. Partial intestinal obstruction 2. Gastro-jejunal dilatation</b>  |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (a) (this hospital) attended the deceased from <b>December 21, 1966</b> , to <b>January 15, 1967</b> , that (b) (we) last saw the deceased alive on <b>January 15, 1967</b> , and that death occurred at <b>7:15 A.M.</b> from causes and on the date stated above.                                     |   |  |   |
| 22a. SIGNATURE<br>   |   | 22b. DATE SIGNED<br><b>January 15, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Reynaldo Orjuela-Gomez, M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Road, Towson 4, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1/18/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GARDENS OF FAITH</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. MD.</b>                        |
| 24. FUNERAL DIRECTOR<br><b>J.G. CONNELL SONS</b>   |   | 25a. REC'D BY REGISTRAR<br><b>300 MACE</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br>   |   | DATE<br><b>JAN 17 1967</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00247

CERTIFICATE OF DEATH

00249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

|   |                                  |   |                                       |
|---|----------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Halethorpe</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>03.1</b>  |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1723 Selma Avenue</b>  |                                  | d. STREET ADDRESS<br><b>1723 Selma Avenue</b>   |                                       |
| 3. NAME OF DECEASED (Type or print)<br>First <b>LOT</b> Middle <b>W.</b> Last <b>DISNEY</b>   |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>15</b> Year <b>1967</b>   |                                       |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-19-1881</b> |
| 9. AGE (In years last birthday) <b>85</b> yrs   |                                  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>10</b> Hours <b>10</b> Min   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |                                       |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                       |
| 13. FATHER'S NAME<br><b>Wesley Disney</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Susann Warfield</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>717-07-8393</b>   |                                       |
| 17. INFORMANT<br><b>Mrs. Hester D. Disney, 1723 Selma Ave.</b>  |                                  | Address   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b><br>DUE TO (b) <b>Cardio Vascular disease</b><br>DUE TO (c) <b>Arteriosclerosis of aorta</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>10 day</b><br><b>1 yr</b> |                                  |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>None</b>  |                                  |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 13, 1967</b> , to <b>Jan 14, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 13, 1967</b> , and that death occurred at <b>4:22 PM</b> from causes and on the date stated above.   |                                  |   |                                       |
| 22a. SIGNATURE<br><b>Dr. Bruce Brumbaugh</b> M.D.   |                                  | 22b. DATE SIGNED<br><b>Jan 18 1967</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Bruce Brumbaugh</b>  |                                  | 22d. ADDRESS<br><b>5609 Main Street, Elkridge, Maryland</b>   |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1-18-1967</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Emmanuel Baust Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Westminster, Md.</b>  |                                       |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 18 1967</b>  |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |                                       |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div> <div>00248</div> <div> <div>00250</div> <div>00250</div> </div> </div> <div> <div> <div>00248</div> <div>00250</div> </div> <div> <div>00250</div> <div>00250</div> </div> </div>   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|---|--|--|---|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <b>MARYLAND</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>c. LENGTH OF STAY IN 1b <u>5 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Centre</u>  |  |  |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>Charles 9 31st Street</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>MARIA</u> Middle <u>KERR</u> Last <u>DOBBIN</u>  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>JANUARY</u> Day <u>17</u> Year <u>1967</u> |  |  | <b>5. SEX</b><br><u>F</u>  |  |  | <b>6. COLOR OR RACE</b><br><u>Can.</u>   |  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  |  | <b>8. DATE OF BIRTH</b><br><u>2-15-1880</u> |  |  | <b>9. AGE</b> (In years last birthday) <u>86</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u> |  |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  |  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>  </u>  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Eastern Shore, Md</u> |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>U.S.A.</u>  |  |  |   |  |  |   |  |  |
| <b>13. FATHER'S NAME</b><br><u>TILTON HEMSLEY</u>   |  |  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>THOMAS.</u>  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) <u>  </u>  |  |  |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>214-72-3467</u>   |  |  | <b>17. INFORMANT</b><br><u>As chart</u>  |  |  | <b>Address</b><br><u>  </u>   |  |  |   |  |  |   |  |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure.</u><br>(b) <u>Myocardial infarction</u><br>(c) <u>Arterio-sclerotic vascular disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>  |  |  |  |  |  |  |  |  |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>  </u>  |  |  |   |  |  |   |  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>  </u> <b>Hour</b> a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town)</b> (County) (State) <u>  </u> |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan. 13th</u> , 1967, <b>to</b> <u>Jan. 14th</u> , 1967, <b>that (I) (we) last saw the deceased alive on</b> <u>Jan. 17th</u> , 1967, <b>and that death occurred at</b> <u>5:30 PM</u> , <b>from the causes and on the date stated above.</b>   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |   |  |  |   |  |  |
| <b>22a. SIGNATURE</b><br><u>M. Isabelle MacGregor</u>   |  |  |  |  |  | <b>22b. DATE SIGNED</b><br><u>1-17-67</u>  |  |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>M. ISABELLE MacGREGOR</u>                    |  |  | <b>22d. ADDRESS</b><br><u>Greater Baltimore Medical Centre</u>  |  |  |   |  |  |   |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>   |  |  | <b>23b. DATE THEREOF</b><br><u>1-19-67</u>                                     |  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Grace Episcopal Church</u>   |  |  | <b>23d. LOCATION (City, town or county)</b> (State) <u>Elkridge Md.</u>                |  |  |   |  |  |   |  |  |   |  |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>H.W. Jenkins</u>  |  |  |  |  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>7 Sons Co.</u>  |  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>4905 York Rd., Balto</u>                       |  |  |   |  |  |   |  |  |   |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00249

## CERTIFICATE OF DEATH

00251

|  |                                      |   |  |
|--|--------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                      | c. LENGTH OF STAY IN lb<br><b>8yrs. 27dys</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore, Maryland 21230</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                      | d. STREET ADDRESS<br><b>126 West Clements St.</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Cornelia</b> Middle <b>Carneal</b> Last <b>Dorman</b>  |                                      | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>30</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>female</b>  | 6. COLOR OR RACE<br><b>white</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Jan. 12, 1875</b>   |
| 9. AGE (In years last birthday)<br><b>92</b>   |                                      | 10. IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                      | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>housewife</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland Virginia</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |
| 13. FATHER'S NAME<br><b>Leland Carneal</b>   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Virginia Muellner</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMY OR NAVY FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                      | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                      | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO <b>ASHD</b><br>DUE TO <b>Generalized Arteriosclerosis</b>  |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>acute</b><br><b>40 yrs.</b><br><b>40 yrs.</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Bronchial pneumonia, organism unknown</b>  |                                      | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                      | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                      | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <b>Dr.</b> (this hospital) attended the deceased from <b>Dec. 28</b> , 19 <b>67</b> , to <b>1967</b> , that (I) (we) lost saw the deceased alive on <b>1-30</b> , 19 <b>67</b> , and that death occurred at <b>8 P</b> M, from causes and on the date stated above. |                                      |   |  |
| 22a. SIGNATURE<br><b>Anthony J. Young, M.D.</b>  |                                      | 22b. DATE SIGNED<br><b>1/30/67 9:30</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>  |                                      | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>2-3-1967</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or town) (County) (State)<br><b>3801 Frederick Ave. Balto., Md</b>                               |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>  |                                      | 25a. REC'D BY REGISTRAR<br><b>FEB 2 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                      |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100



00250

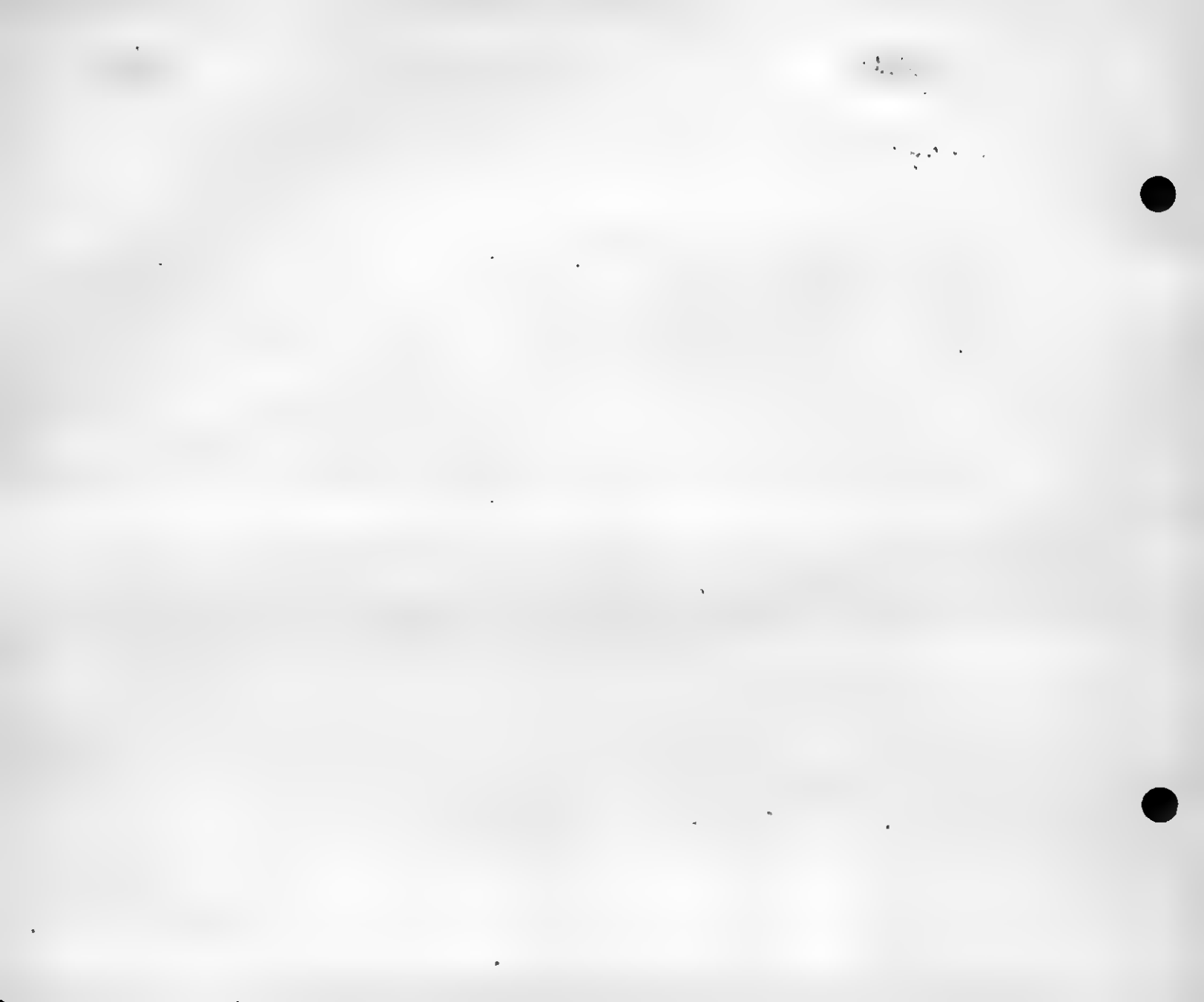
## CERTIFICATE OF DEATH

00252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i><br>MARYLAND   |                                     | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>✓</i>                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Catonsville</i>   |                                     | c. LENGTH OF STAY IN <i>3 mo 27 d</i>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Spring Grove State Hospital</i>   |                                     | d. STREET ADDRESS<br><i>2319 Annapolis Road</i>  |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <i>GORDON</i> Middle <i>A</i> Last <i>EADES</i>   |                                     | 4. DATE OF DEATH<br>Month <i>January</i> Day <i>14</i> Year <i>1967</i>  |  |
| 5 SEX<br><i>M</i>  | 6 COLOR OR RACE<br><i>W</i>         | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>March 25 1890</i>                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Railroad</i>   | 9 AGE (In years last birthday)<br><i>76</i> yrs                            |
| 13. FATHER'S NAME<br><i>GORDON</i>   |                                     | 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.</i>  |  |
| 16. SOCIAL SECURITY NO.<br><i>705-10-6388</i>  |                                     | 17. INFORMANT<br><i>Reverend Spring Grove State Hosp.</i>  |  |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Cachexia</i><br>DUE TO (b) <i>malnutrition</i><br>DUE TO (c) <i>Atherosclerosis, severe</i>  |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><i>20 days</i>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Chronic Brain Syndrome &amp; psychotic reaction</i>  |                                     |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                     |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <i>19</i>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Sept 7</i> , 19 <i>65</i> , to <i>1-14</i> , 19 <i>67</i> that (I) (we) last saw the deceased alive on <i>1-14</i> , 1967, and that death occurred at <i>1:40</i> P.M., from causes and on the date stated above. |                                     |  |  |
| 22a. SIGNATURE<br><i>D. Imte KUPITS</i> M.D.   |                                     | 22b. DATE SIGNED<br><i>Jan-14, 1967</i>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>D. Imte KUPITS</i>  |                                     | 22d. ADDRESS<br><i>Spring Grove State Hospital</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   | 23b. DATE THEREOF<br><i>1/18/67</i> | 23c. NAME OF CEMETERY OR CREMATORY<br><i>GLEN HAVEN</i>  | 23d. LOCATION (City or Town) (County) (State)<br><i>GLEN BERNIE AA MD.</i> |
| 24. FUNERAL DIRECTOR<br><i>McGOLLY FUNERAL HOME</i>  |                                     | 25a. REC'D BY REGISTRAR<br>DATE <i>JAN 17 1967</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. [Signature]</i>  |                                     |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00251

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 5 231m 4505

1/22/67 mb

00252

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>                                 |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>209 C. Joppa Road</u>                          |  |  |  | d. STREET ADDRESS<br><u>209 C. Joppa Road</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Ernest</u> Middle <u>Anton</u> Last <u>Escery</u>                                 |  |  |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>17</u> Year <u>1967</u>   |  |  |  |
| 5. SEX<br><u>Male</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><u>January 2, 1898</u>                                     |  |
| 9. AGE (In years last birthday)<br><u>68</u> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Chiropractor</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Self employed</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Hungary</u>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 13. FATHER'S NAME<br><u>Stephen Escery</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Marie Brana</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>No</u> |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Family Records</u>   |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinomatosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Carcinoma of Rectum</u><br>(c) <u></u> |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 yrs.</u>                              |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)                                      |  |  |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  |  |  |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                         |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  | 21. I certify that (I) (this hospital) attended the deceased from <u>1-16-</u> , 1967, to <u>1-16-</u> , 1967, that (I) (we) last saw the deceased alive on <u>1-16-</u> 1967, and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.                                     |  |  |  |
| 22a. SIGNATURE<br><u>M. X. Quinn</u>  |  |  |  | 22b. DATE SIGNED<br><u>1-20-67</u>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>M. KEVIN QUINN MD</u>  |  |  |  | 22d. ADDRESS<br><u>1927 York RD, TIMONIAH, Balt. Md</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Cremated</u>  |  |  |  | 23b. DATE THEREOF<br><u>Jan. 20, 1967</u>   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount Cemetery</u>  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><u>Baltimore, Maryland</u>  |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>   |  |  |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |  |  | DATE<br><u>JAN 23 1967</u>  |  |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00252

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00252

|   |                                  |   |                                    |
|---|----------------------------------|---|------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                  |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>  |                                  | c. LENGTH OF STAY IN TB<br><b>4 Months</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1813 East Ave.</b>   |                                  | e. STREET ADDRESS<br><b>1813 East Ave.</b>  |                                    |
| 3 NAME OF DECEASED (Type or print)<br><b>Caroline</b>   |                                  | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>24</b> Year <b>67</b>  |                                    |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/19/85</b> |
| 9. AGE (In years last birthday)<br><b>81</b> yrs  |                                  | 10. IF UNDER 1 Year<br>Months <b>24</b> Days <b>19</b> Hours <b>67</b> Min  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Arco Paint Co.</b>  |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>? Teffs</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Net Known</b>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>271-22-8787</b>  |                                    |
| 17. INFORMANT (Son)<br><b>Edward Edelburg, 1813 East Ave. Dundalk Md.</b>   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cornary Occlusion</b><br>DUE TO <b>A-S-C-V-Disease</b><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b)<br>(c)<br>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)                    |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>None</b>   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>    |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |                                    |
| ACTUAL SIGNATURE<br><b>Melvin B. Davis</b>  |                                  | 22. DATE SIGNED<br><b>6800 Morning- 1/25/67</b>   |                                    |
| EXAMINER'S NAME (Type)<br><b>M. D.</b>  |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)<br><b>ton Rd. Dundalk, Md.</b>                          |                                    |
| 23a. BURIAL (CREMATION, REMOVAL) (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/27/67</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Lutheran Cemetery</b>   |                                  | 23d. LOCATION (City or town) (County) (State)<br><b>Baltimore, Md.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda 7922 Wise Ave. Dundalk, Md.</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 26 1967</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  |   |                                    |

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00253

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00255

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto.</b> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                        |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Randallstown</b>  |                                  | c. LENGTH OF STAY IN 1b<br><b>D.O.A.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Balto. Co. Gen. Hosp.</b>   |                                  | e. STREET ADDRESS<br><b>3407 Kimble Road</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>Andrew B. Eickhoff</b>   |                                  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>19</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Aug. 11, 1899</b> |
| 9. AGE (In years last birthday) yrs<br><b>67</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Minister</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Retired</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>New Jersey</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Herman Eickhoff</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Ann Blumenstock</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><b>yes WW I</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>1</b>  |  |
| 17. INFORMANT<br><b>Mrs. Ruth L. Eickhoff, 3407 Kimble Rd., Balto.</b>   |                                  | Address <b>7, Md.</b>   |  |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b><br><b>422.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b) _____<br>(c) _____   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br><b>none</b>  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>none</b> 19<br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>none</b>  |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE <b>D. D. Caples</b> M.D.  |                                  | 22. DATE SIGNED<br><b>1-20-67</b>   |  |
| EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>  |                                  | 6 Hanover Rd., <b>Baltimore, Md.</b>  |  |
| 23a. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1-23-1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave., Balto.</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 24 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                             |  |  |  |  |  |   |  |   |  |
|--|--|-----------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                             |  |  |  |  |  |   |  |   |  |
| 00254  |  |                             |  |  |  | 00256  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |                             |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |                             |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>3611 Delverne Rd. BALTIMORE</u>                          |  |   |  |   |  |
| c. LENGTH OF STAY IN ID <u>1 week</u>  |  |                             |  |  |  | d. STREET ADDRESS <u>3611 Delverne Rd.</u>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med Ctr</u>  |  |                             |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Annetta (NIA) ELKISON</u>   |  |                             |  |  |  | 4. DATE OF DEATH <u>Jan 30 1967</u>  |  |   |  |   |  |
| 5. SEX <u>female</u>   |  | 6. COLOR OR RACE <u>Can</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>3-6-84</u>   |  | 9. AGE (In years last birthday) <u>82 yrs.</u>  |  | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.                 |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>   |  |                             |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>B.A. Co. Maryland</u>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                              |  |
| 13. FATHER'S NAME <u>George Calvert</u>  |  |                             |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Blunt</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  |                             |  |  |  | 16. SOCIAL SECURITY NO. <u>216-058150</u>  |  | 17. INFORMANT <u>Patients Chart</u> Address     |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u><br>DUE TO <u>PNEUMONIA</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO <u>EMPHYSEMA WITH COR PULMONALE</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE WITH CONGESTIVE FAILURE</u> |  |                             |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>                        |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                             |  |  |  |  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                             |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                             |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)            |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-23-</u> 19 <u>67</u> , to <u>1-30-1967</u> , that (I) (we) last saw the deceased alive on <u>1-30-</u> 19 <u>67</u> , and that death occurred at <u>11:40AM</u> , from the causes and on the date stated above.   |  |                             |  |  |  |  |  |   |  |   |  |
| 22a. SIGNATURE <u>E.K.S. Narayanan</u>   |  |                             |  |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/>  |  | MED. DIRECTOR <input type="checkbox"/>          |  | STAFF PHYS. <input checked="" type="checkbox"/>                         |  |
| 22c. PHYSICIAN'S NAME (Type) <u>EDATHIL K.S. NARAYANAN</u>   |  |                             |  |  |  | 22d. ADDRESS <u>INTERN, GREATER BALTO. MED. CENTER - MD. 21204</u>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                             |  | 23b. DATE THEREOF <u>2-2-1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Magothy Meth. Church</u>   |  |   |  | 23d. LOCATION (City, town or county) (State) <u>AnneArundel Co. Md.</u> |  |
| 24. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto. Md. 21212</u>   |  |                             |  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |   |  |

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00255

00257

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arbutus</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Arbutus</b> 05.1   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1007 St. Charles Avenue</b>   |  | d. STREET ADDRESS<br><b>1010 St. Charles Avenue</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>PETER C. ELLSTROM</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>9</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-9-1892</b>   |
| 9. AGE (in years last birthday)<br><b>74</b> yrs   |  | 10. IF UNDER 1 YEAR<br>Months <b>7</b> Days <b>10</b> Hours <b>10</b> Min <b>00</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Boilmaker</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>New York</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Gustaf Ellstrom</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Hilda Ellstrom</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><b>Mrs. Christine Douden, St. Petersburg, Fla.</b>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Anti Coronary occlusion</b><br>DUE TO (b) <b>ASCUD</b><br>DUE TO (c) <b>ASCUD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  |   |   |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>10 minutes</b>  |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>Where <input type="checkbox"/> Not Where <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 2, 1966</b> to <b>Jan 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 6, 1967</b> , and that death occurred at <b>8:15 P.M.</b> from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Earl I. Pass</b>  |  | 22b. DATE SIGNED<br><b>1-10-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Earl I. Pass</b>  |  | 22d. ADDRESS<br><b>4001 Wilkens Avenue, Balto. Md. 29</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-12-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 12 1967</b>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
SM 1/63

1M

00256

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00258

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>PERRY HALL</b>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>PERRY HALL</b>                                     |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>9531 HORN AVE.</b>  |  |   |  | d. STREET ADDRESS<br><b>9531 HORN AVE. 31236</b>  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>CARROLL. JOSEPH EWERS.</b>  |  | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>25</b> Year <b>1967</b>                                       |  | 5. SEX<br><b>M.</b>   |  | 6. COLOR OR RACE<br><b>W.</b>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>9-6-1891</b>   |  | 9. AGE (In years last birthday)<br><b>75</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>                           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Car enter</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Edgewood Md.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                               |  |
| 13. FATHER'S NAME<br><b>Frederick Ewers</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret O'Brien</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-07-2579A</b>  |  | 17. INFORMANT<br>Address<br><b>Mrs Mary E. Ewers 9531 Horn Avenue</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Dissecting Aortic Aneurysm</b><br>DUE TO (b) <b>Atherosclerotic Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.<br>DUE TO (c) <b>undet.</b>   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>undet.</b>                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):   |  |   |  |   |  |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                       |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |   |  |  |  |
| ACTUAL SIGNATURE<br><b>JOAN P. Hyle</b>  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>                |  |
| EXAMINER'S NAME (Type)<br><b>JOAN P. Hyle</b>  |  | M.D.  |  | Address (Street, city, town, or county)<br><b>1-25-67</b>   |  | DATE SIGNED  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 22b. DATE THEREOF<br><b>1-28-1967</b>   |  | 22c. NAME OF CEMETERY OR CREMATORY<br><b>St/ Joseph's Cemetery</b>  |  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Co. Md.</b> |  |
| 23. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home 7801 Belair Rd.</b>  |  |   |  | 24. REC'D BY REGISTRAR<br><b>JAN 30 1967</b>  |  |  |  |
| 25. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |   |  | 26. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div style="display: flex; justify-content: space-between;"> <div> <p>1. PLACE OF DEATH<br/>a. COUNTY<br/><b>Baltimore County</b><br/>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br/><b>Mount Wilson</b><br/>c. LENGTH OF STAY IN 1b<br/><b>1 month</b><br/>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br/><b>Mount Wilson State Hospital</b></p> </div> <div> <p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br/>a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b><br/>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br/><b>ROCKVILLE</b><br/>d. STREET ADDRESS<br/><b>1300 VANDALIA DRIVE</b><br/>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div> |  |                                  |                           |   |  |   |  |  |   |  |  |  |  |  |
|--|--|----------------------------------|---------------------------|---|--|---|--|--|---|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or print)  |  |                                  | First<br><b>JOSEPHINE</b> |   |  | Middle<br><b>MARTHA</b>   |  |  | Last<br><b>FARRAR</b>                             |  |  | 4. DATE OF DEATH<br>Month<br><b>1</b><br>Day<br><b>12</b><br>Year<br><b>1966</b> |  |  |
| 5. SEX<br><b>FEMALE</b>  |  | 6. COLOR OR RACE<br><b>WHITE</b> |                           | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/22/28</b>                              |  |  | 9. AGE (In years last birthday)<br><b>38</b> yrs. |  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.                       |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |  |                                  |                           | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>KANSAS</b>   |   |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                       |  |  |
| 13. FATHER'S NAME<br><b>CHESTER SHELLMAN</b>   |  |                                  |                           |   |  | 14. MOTHER'S MAIDEN NAME<br><b>CLEO SHRECK</b>                  |  |  |   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  |                                  |                           | 16. SOCIAL SECURITY NO.<br><b>515-14-248</b>  |  |   |  | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>             |   |  |  | Address  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CHRONIC OBSTRUCTIVE PULMONARY</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>EMPHYSEMA</b><br>DUE TO (c)   |  |                                  |                           |   |  |   |  |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 years</b>                              |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                                  |                           |   |  |   |  |  |   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |   |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                  |                           | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   |  |  | 20f. (City or town) (County) (State)   |  |  |
| 21. I certify that (this hospital) attended the deceased from <b>12/12, 1966</b> , to <b>1/12, 1967</b> , that (we) last saw the deceased alive on <b>1/12, 1967</b> , and that death occurred at <b>1:20 P.M.</b> , from the causes and on the date stated above.   |  |                                  |                           |   |  |   |  |  |   |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>  |  |                                  |                           |   |  |   |  |  |   |  |  | 22b. DATE SIGNED<br><b>1/12/68</b>   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>  |  |                                  |                           |   |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>                   |  |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  |                           | 23b. DATE THEREOF<br><b>1/17/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b> |  |  |   | 23d. LOCATION (City, town or county) (State)<br><b>Arlington, Virginia</b> |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Iyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>   |  |                                  |                           |   |  |   |  |  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 16 1967</b>                              |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>                            |  |  |



00258

CERTIFICATE OF DEATH

00260

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |   |   |   |
|---|----------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>Essex 21221</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  |   |   | e. STREET ADDRESS<br><b>513 Back River Neck Rd.</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elizabeth</b> Middle <b>Clara</b> Last <b>FERSTERMANN</b>   |                                  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>1967</b>  |   |   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 28, 1897</b> | 9. AGE (In years last birthday)<br><b>69</b> yrs  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>12</b> Hours <b>1</b> Min <b>12</b>                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Germany</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                  | 13. FATHER'S NAME<br><b>Charles Hahn</b>  |   |   |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Clara Ahrens</b>   |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   |   |   |
| 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                  | 17. INFORMANT<br><b>Richard Ferstermann</b> Address <b>513 Back River Neck Rd.</b>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>576X</b> IMMEDIATE CAUSE (a) <b>Generalized Peritonitis</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pulmonary Thrombo-Embolus</b>   |                                  |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>                          |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |   |
| 20f. (City or town)   |                                  | (County)  |   | (State)   |   |
| 21. I certify that <b>A</b> (this hospital) attended the deceased from <b>12/29/</b> , 19 <b>66</b> , to <b>1/6/</b> , 19 <b>67</b> , that <b>OK</b> (we) last saw the deceased alive on <b>1/6/</b> , 19 <b>67</b> , and that death occurred at <b>12 A.M.</b> , from causes and on the date stated above.           |                                  |   |   |   |   |
| 22a. SIGNATURE<br><b>Reynaldo Oajuela-Gomez</b>   |                                  |   |   | 22b. DATE SIGNED<br><b>1/6/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. M.D.</b>   |                                  |   |   | 22d. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1/9/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Pk.</b>  |   |
| 23d. LOCATION (City or Town)<br><b>Baltimore, Co., Maryland</b>   |                                  |   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Brudzinski Funeral Home</b>  |                                  | ADDRESS<br><b>1407 Eastern Ave.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 9 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>  |                                  |   |   |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

|   |   |  |  |
|---|---|--|--|
| 00259   |   | 00261  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Rural)</u><br>c. LENGTH OF STAY IN ID <u>10 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltimore Medical Center</u>  |   | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore #18</u><br>d. STREET ADDRESS <u>1607 E 29th Street</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Charlotte</u> Middle <u>Catherine</u> Last <u>Fingles</u>   |   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>10</u> Year <u>1967</u>  |  |
| 5. SEX <u>FEMALE</u>  | 6. COLOR OR RACE <u>White</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>April 13, 1902</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <u>70 yrs.</u><br>IF UNDER 1 YEAR: Months <u>7</u> Days <u>10</u> Hours <u>13</u> Min. <u>00</u> |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>Baltimore</u>  |  |
| 13. FATHER'S NAME <u>ANTHONY JOSEPH WALKER</u>  |   | 14. MOTHER'S MAIDEN NAME <u>Hungate Mary Hulse</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO. <u>213-03-6742</u>   | 17. INFORMANT <u>Thomas J Fingles</u> Address <u>Same</u>  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>PULMONARY THROMBOEMBOLISM</u><br>200.2<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>MALIGNANT LYMPHOMA</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Hrs</u><br><u>MOS.</u>  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-2, 1967</u> to <u>1-10, 1967</u> that (I) (we) last saw the deceased alive on <u>1-9, 1967</u> , and that death occurred at <u>1054 PM</u> from the causes and on the date stated above.   |   |  |  |
| 22a. SIGNATURE <u>Manuel A. Hongon</u> M.D.   |   | 22b. DATE SIGNED <u>1-10-67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)  |   | 22d. ADDRESS   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>   | 23b. DATE THEREOF <u>1/14/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>   | 23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>  |
| 24. FUNERAL DIRECTOR <u>L. J. Ruck Inc</u> ADDRESS <u>5305 Harford Rd.</u>  |   | 25a. REC'D BY REGISTRAR <u>13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |



00260

## CERTIFICATE OF DEATH

00262

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                           |   |                             |
|---|---------------------------|---|-----------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>                              |                             |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                           | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                             |
| c. LENGTH OF STAY IN 1b <u>2 yrs</u>  |                           | d. STREET ADDRESS <u>2709 Oakley Ave.</u>   |                             |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Caton Ridge Nursing Home</u>  |                           | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                             |
| 3. NAME OF DECEASED (Type or print) <u>Harry Finkelstein</u>  |                           | 4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1967</u>  |                             |
| 5. SEX <u>M</u>   | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>unk</u> |
| 9. AGE (In years or birthday) <u>85</u> yrs.  |                           | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>   |                             |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired) <u>tailor</u>   |                           | 10b. KIND OF BUSINESS OR INDUSTRY <u>unk</u>  |                             |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>   |                           | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |                             |
| 13. FATHER'S NAME <u>unk</u>  |                           | 14. MOTHER'S MAIDEN NAME <u>unk</u>   |                             |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                           | 16. SOCIAL SECURITY NO. <u>212-07-5750A</u>   |                             |
| 17. INFORMANT <u>Nursing Home Chart</u>   |                           | Address   |                             |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>DUE TO (b) <u>Coronary Arteriosclerosis</u><br>DUE TO (c) <u>Arteriosclerotic Cardiovascular Dis</u>                                  |                           |   |                             |
| INTERVAL BETWEEN ONSET AND DEATH <u>40 yrs</u>  |                           |   |                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Decubitus Ulcers</u>  |                           |   |                             |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                           |   |                             |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                           | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                             |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>   |                           | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>            |                             |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)  |                             |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/30</u> , 19 <u>66</u> , to <u>1/13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1/13</u> , 19 <u>67</u> and that death occurred at <u>2:15 AM</u> , from causes on and the date stated above. |                           |   |                             |
| 22a. SIGNATURE <u>David E. Zickafoose</u> M.D.  |                           | 22b. DATE SIGNED <u>1/13/67</u>   |                             |
| 22c. PHYSICIAN'S NAME (Type) <u>David E. Zickafoose, M.D.</u>   |                           | 22d. ADDRESS <u>445 W. Lane, Ell City, Md.</u>  |                             |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                           | 23b. DATE THEREOF <u>1-15-67</u>  |                             |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Bobroisker Beneficial</u>   |                           | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>   |                             |
| 24. FUNERAL DIRECTOR <u>Salvatore Bros. Inc. - Baltimore</u>  |                           | 25a. REC'D BY REGISTRAR <u>6010</u>   |                             |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |                           | DATE <u>JAN 20 1967</u>   |                             |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

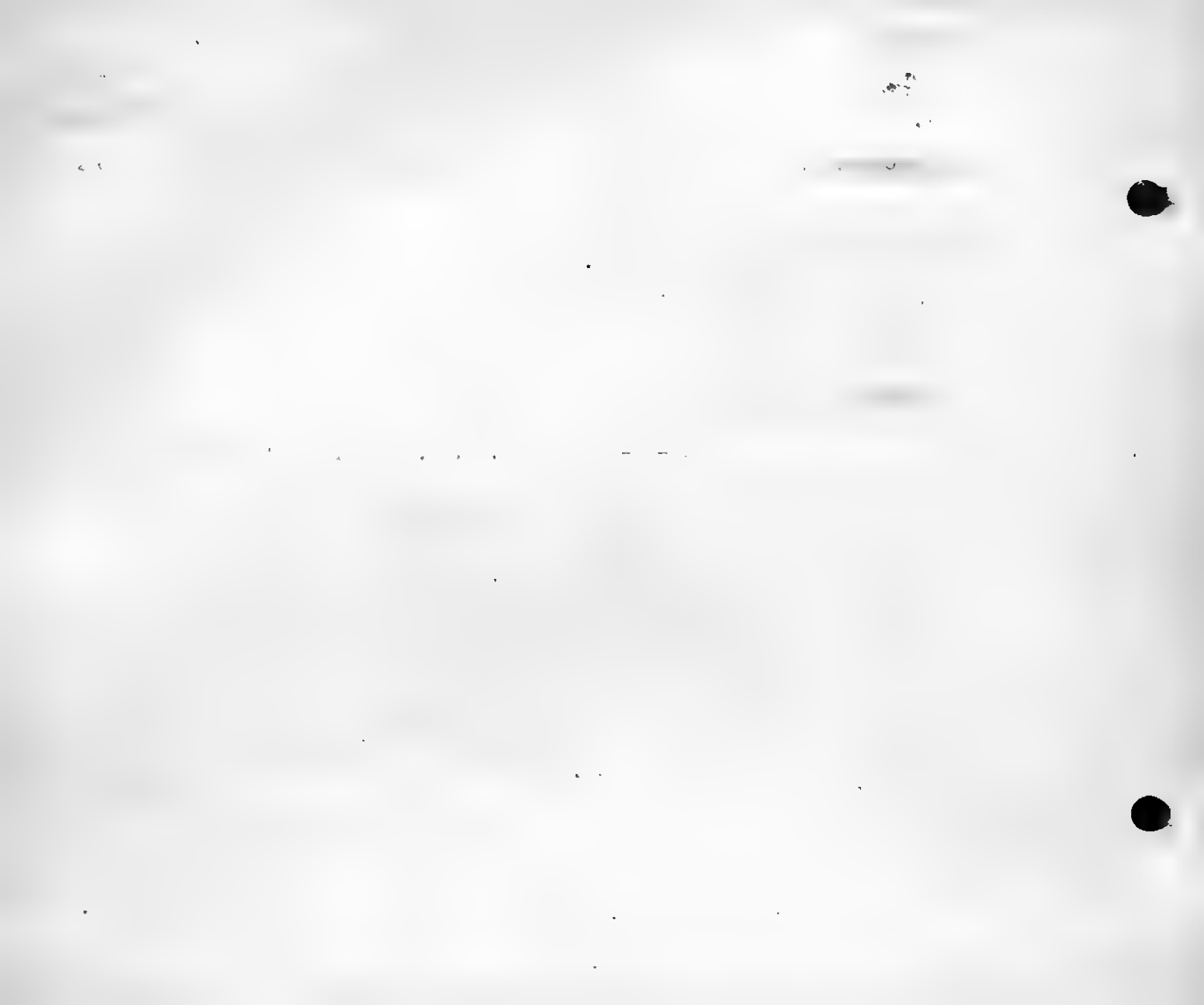
| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                           |  |  |  |  |  |  |  |   |  |
|--|--|---------------------------|--|--|--|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                           |  |  |  |  |  |  |  |   |  |
| 00261  |  |                           |  |  |  | 00263  |  |  |  |   |  |
| 1. PLACE OF DEATH  |  |                           |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                  |  |  |  |   |  |
| a. COUNTY <u>Baltimore.</u> MARYLAND   |  |                           |  |  |  | a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore.</u>   |  |  |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>   |  |                           |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Monkton.</u> |  |  |  |   |  |
| c. LENGTH OF STAY IN 1b <u>1 mo.</u>   |  |                           |  |  |  | d. STREET ADDRESS <u>Monkton Rd.</u>   |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dulaney-Towson Conv. Home.</u>   |  |                           |  |  |  | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>         |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Clarence Edgar Fishel</u>   |  |                           |  |  |  | 4. DATE OF DEATH <u>January 22, 1967</u>   |  |  |  |   |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>June 15, 1881</u>  |  | 9. AGE (In years last birthday) <u>85</u> yrs.                               |  | IF UNDER 1 YEAR: Months <u>8</u> Days <u>22</u> Hours <u>11</u> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegrapher</u>   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad.</u>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Stewartstown, Pa.</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                            |  |
| 13. FATHER'S NAME <u>Daniel Fishel</u>   |  |                           |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Margaret Thompson</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  |                           |  |  |  | 16. SOCIAL SECURITY NO. <u>717-07-7908</u>   |  |  |  |   |  |
| 17. INFORMANT <u>Mrs. Mabel Fishel, Monkton, Md. 21111.</u>  |  |                           |  |  |  | Address  |  |  |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of left kidney</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>100%</u><br>DUE TO (c) |  |                           |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>                        |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                           |  |  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  |                           |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                           |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                 |  | 20f. (City or town) (County) (State)   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January, 1966</u> , to <u>Jan 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 22, 1967</u> , and that death occurred at <u>7:50 PM</u> , from the causes and on the date stated above.                         |  |                           |  |  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <u>Loy M. Zimmerman</u> M.D.  |  |                           |  |  |  | 22b. DATE SIGNED <u>Jan. 22, 67</u>  |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman MD</u>  |  |                           |  |  |  | 22d. ADDRESS <u>3202 Hartford Rd. Baltimore, Md.</u>   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                           |  | 23b. DATE THEREOF <u>Jan 24, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Shrewsbury Lutheran</u>  |  |  |  | 23d. LOCATION (City, town or county) (State) <u>Shrewsbury Penna.</u> |  |
| 24. FUNERAL DIRECTOR <u>Isaac Hartenstein, New Freedom, Pa.</u>  |  |                           |  |  |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  |  |  |   |  |
|  |  |                           |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |   |  |
|  |  |                           |  |  |  | DATE <u>JAN 25 1967</u>  |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
|---|--|--|---|--|---|--|--|---|--|---|--|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
| CERTIFICATE OF DEATH  |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
| 00262   |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |   |  |   |  |                                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |  |  |   | c. LENGTH OF STAY IN 1b<br><u>6 HRS.</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |  |   |  |   |  |                                  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Greater Baltimore Medical Center</u>   |  |  |   |  |   | d. STREET ADDRESS<br><u>3939 Tolson Avenue</u>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                                  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Emma</u> Middle <u>L.</u> Last <u>Fitzell</u>  |  |  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>16</u> Year <u>1967</u> |  |   | 5. SEX<br><u>Female</u>  |  |   | 6. COLOR OR RACE<br><u>White</u>   |   |  |                                  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br><u>1-17-83</u>                                |  |   | 9. AGE (In years last birthday)<br><u>83</u> yrs.  |  |   | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> |   |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore County Maryland</u> |  |   |  |                                  |  |
| 13. FATHER'S NAME<br><u>William R. Lynch</u>  |  |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><u>GRACE, Sara</u>   |  |   |  |   |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>No</u>  |  |  |   | 16. SOCIAL SECURITY NO.<br><u>None</u>   |   | 17. INFORMANT<br><u>Mr. T. R. Fitzell</u>  |  | Address<br><u>3023 Duglow Road</u>  |  |   |  |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio-respiratory failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Myocardial injury, probably infarction</u><br>(c) <u>Coronary disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |   |  |   |  |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)                         |   |  |  |   |  |   |  |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>a.m.</u> <u>19</u> p.m.   |  |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |   |  |                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January 15, 1967</u> to <u>January 15, 1967</u> , that (I) (we) last saw the deceased alive on <u>January 15, 1967</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.  |  |  |   |  |   |  |  |   |  |   |  |                                  |  |
| 22a. SIGNATURE<br><u>D. Kuwilsky</u>  |  |  |   |  |   | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>         |  |   | 22b. DATE SIGNED<br><u>1-16-67</u>   |   |  |                                  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dora C. Kuwilsky</u>   |  |  |   |  |   | 22d. ADDRESS<br><u>Greater Baltimore Medical Center</u>  |  |   |  |   |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |  | 23b. DATE THEREOF<br><u>1/19/1967</u>                             |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Caklawn Cemetery</u> |  |  | 23d. LOCATION (City, town or county) (State)<br><u>Baltimore County, Md.</u>            |  |   |  |                                  |  |
| 24. FUNERAL DIRECTOR<br><u>Wm. J. Zupke &amp; Son</u>   |  |  |   |  |   | ADDRESS<br><u>Baltimore, Md. North 2 Pa. Aves.</u>   |  | 25a. REC'D BY REGISTRAR<br><u>JAN 17 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |                                  |  |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1. PLACE OF BIRTH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>                    |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>BALTO-rural Parkville 3mo</u>  |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>BALTO-rural-Parkville 0-1</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>8515-D Old Harford</u>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>ALICE</u> First <u>IDA</u> Middle <u>FLETCHER</u> Last  |                                  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>1</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-17-1912</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House Wife</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Home</u>  | 9. AGE in years (last birthday) <u>54</u> yrs.<br>IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>5</u> |
| 11. BIRTHPLACE (State or foreign country)<br><u>Hanover Pennsylvania</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>UNKNOWN</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>UNKNOWN</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>NO</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>219-22-8544</u>   |   |
| 17. INFORMANT<br><u>FREDERICK FLETCHER</u>  |                                  | Address <u>SAME</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE: (a) <u>Atherosclerotic Cardiovascular Disease</u><br>DUE TO (b) <u>4221</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>undit</u>  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>undit</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |   |   |
| ACTUAL SIGNATURE<br><u>John C. Hyle</u>   |                                  | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><u>JOHN C. HYLE</u>   |                                  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |
| 22. DATE SIGNED<br><u>1 Jan 67</u>  |                                  | Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 23b. DATE THEREOF<br><u>1-4-67</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Garden of Faith</u>  |                                  | 23d. LOCATION (City, town or county) (State)<br><u>BALTO MD</u>   |   |
| 24. FUNERAL DIRECTOR<br><u>CHAR. F. EVANS</u>   |                                  | ADDRESS<br><u>8802 Harford Rd</u>   |   |
| 25a. REC'D BY REGISTRAR<br><u>Jan 4 1967</u>  |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>Wojc</u>   |   |



00264

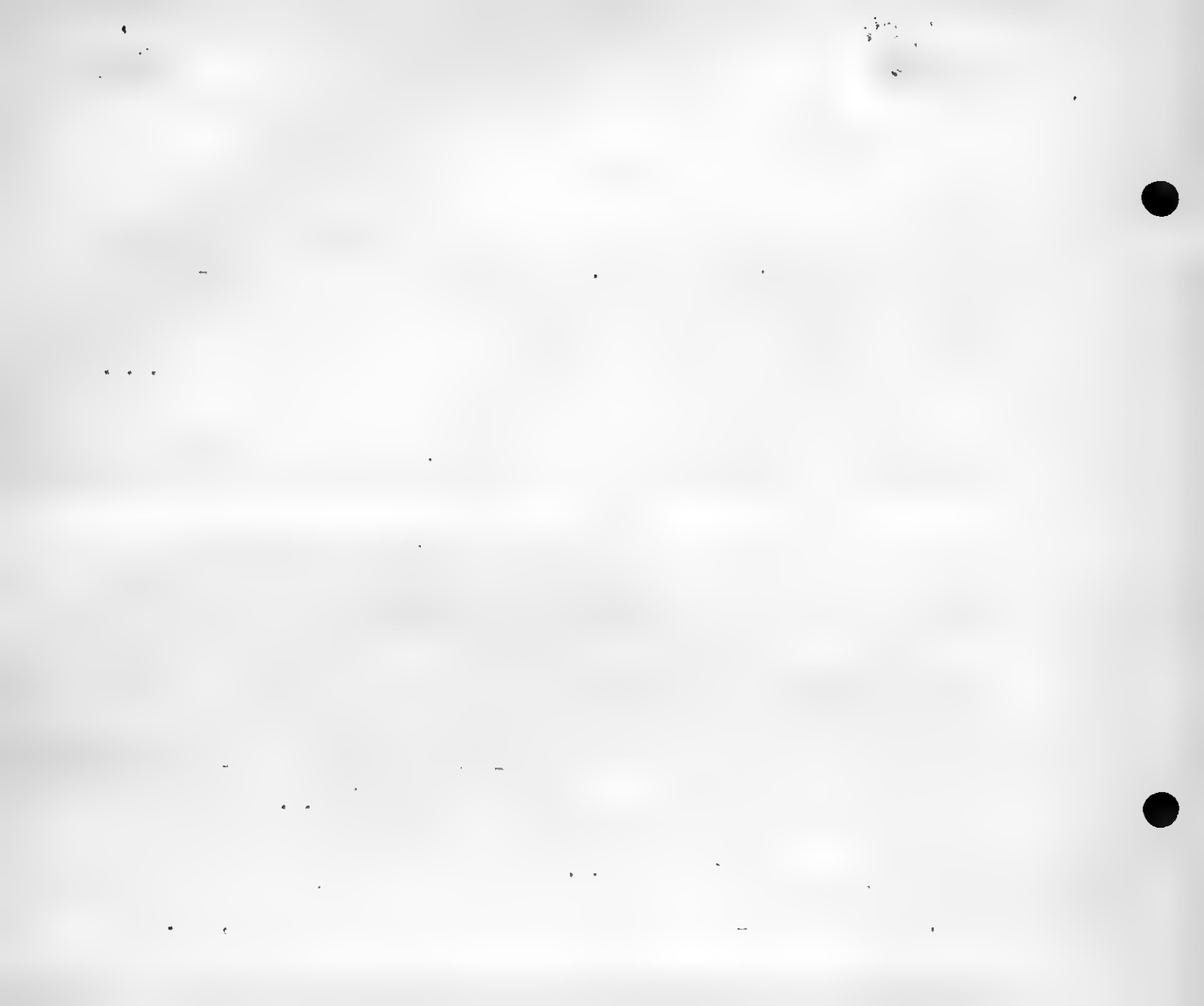
CERTIFICATE OF DEATH

00266

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>2yr6mth28dys</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp ital, give street address)<br><b>Spring Grove State Hospital</b>   |  | e. STREET ADDRESS<br><b>149A Church Road</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Clarence</b> Middle <b>A.</b> Last <b>Fletcher</b>  |  | 4. DATE OF DEATH<br>Month <b>1-12-67</b> Day <b>19</b> Year <b>19</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Negro</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1899</b>                                       |
| 9. AGE (In years last birthday) yrs <b>68</b>   |  | 10. IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> IF UNDER 24 HRS Hours <b>12</b> Min. <b>12</b>   |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 11b. KIND OF BUSINESS OR INDUSTRY  |   |
| 12a. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME  |   |
| 14. MOTHER'S MAIDEN NAME  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |   |
| 16. SOCIAL SECURITY NO  |  | 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO<br>(b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b>                   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>6-11-63</b> , 19 <b>63</b> , to <b>1-12</b> , 19 <b>67</b> that (we) (we) lost saw the deceased alive on <b>1-12-67</b> , 19 <b>67</b> , and that death occurred at <b>9:12 A.M.</b> from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><b>Narcisco Carmona M.D.</b> M.D.   |  | 22b. DATE SIGNED<br><b>1-12-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Narcisco Carmona, M.D.</b>   |  | 22d. ADDRESS<br><b>Spring Grove State Hospital Catonsville, Maryland 21228</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-17-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Harmony Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Landover, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Rollins Fun Home 4339 Hunt Pl NE</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 17 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00265

Item 23b 11

CERTIFICATE OF DEATH

00267

|   |  |  |   |
|---|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b><br>c. LENGTH OF STAY IN 1b<br><b>48 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>                                 |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TURNERS STATION</b><br>d. STREET ADDRESS<br><b>520 NORTH PITTSBURGH AVENUE</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3 NAME OF DECEASED (Type or print)<br>First<br><b>HENRY</b><br>Middle<br><b>C</b><br>Last<br><b>FOSTER</b>  |  | 4. DATE OF DEATH<br>Month<br><b>JANUARY</b><br>Day<br><b>29</b><br>Year<br><b>19 67</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>FEB. 2, 1920</b>  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEELWORKER</b>  |  | 10b KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years (last birthday))<br><b>46</b> yrs.<br>IF UNDER 1 YEAR<br>Months Days<br>IF UNDER 24 HRS.<br>Hours Min. |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>CLARKE COUNTY, GEORGIA</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILL HENRY FOSTER</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>BLANNIE</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW-11</b>  |  | 16. SOCIAL SECURITY NO.<br><b>260 12 6277</b>  |   |
| 17. INFORMANT<br><b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS ADVANCED</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 MONTHS</b> |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DIABETES MELLITUS, CEREBRAL ARTERIOSCLEROSIS</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> at work<br>Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) _____ (County) _____ (State) _____  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>DEC. 12, 1966</b> , to <b>JAN. 29, 1967</b> , that (X) (we) last saw the deceased alive on <b>JAN. 29, 1967</b> , and that death occurred at <b>1:30 P. M.</b> from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><i>W. J. Hahn</i>   |  | 22b. DATE SIGNED<br><b>1/29/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type) <b>WON JU HAHN, M.D.</b>   |  | 22d. ADDRESS<br><b>VAH, FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>2/2/1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND</b>  |  | 23d. LOCATION (City or Town) _____ (County) _____ (State) _____  |   |
| 24. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett</b><br><b>1701 Laurens St.</b><br><b>Baltimore, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 31 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |  |   |



00266

## CERTIFICATE OF DEATH

00268

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <b>MARYLAND</b> b. COUNTY                               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>   |   | c. LENGTH OF STAY IN Tb  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>FOREST HAVEN NURSING HOME</b>   |   | d. STREET ADDRESS<br><b>5514 Heatherwood Rd</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Joseph HENRY FULLER</b>  |   | 4. DATE OF DEATH<br>Month <b>JAN.</b> Day <b>12</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 26, 1891</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NEVER EMPLOYED</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>75</b> yrs  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>BALTO. Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Joseph Fuller</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNA STOLZENBACH</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 16. SOCIAL SECURITY NO.  |   |
| 17. INFORMANT<br><b>MINNIE WALL</b>  |   | Address<br><b>5514 Heatherwood</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>ACUTE ARTERIO SCLEROSIS CHRONIC VASCULAR</b><br>DUE TO <b>1221</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>DISEASE - CHRONIC VASCULAR</b><br>DUE TO<br>(c) <b>ACCIDENT &amp; ARTERIO SCLEROSIS</b> |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/11</b> , 19 <b>67</b> , to <b>1/14</b> , 19 <b>67</b> , that (I) (we) las saw the deceased alive on <b>1/14</b> , 19 <b>67</b> , and that death occurred at <b>11</b> P.M. from causes and on the date stated above   |   |  |   |
| 22a. SIGNATURE<br><b>John H. Fuller M.D.</b>   |   | 22b. DATE SIGNED<br><b>1/13/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John H. Fuller</b>  |   | 22d. ADDRESS<br><b>5514 Heatherwood Rd. Catonsville Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1/14/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PK. Cem</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTO. Md.</b>                                |
| 24. FUNERAL DIRECTOR<br><b>E. B. Mac Nabbs</b>   |   | 25a. REC'D BY REGISTRAR<br><b>301 Frederick Rd 21228</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   | DATE <b>JAN 16 1967</b>  |   |



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00267

CERTIFICATE OF DEATH

00269

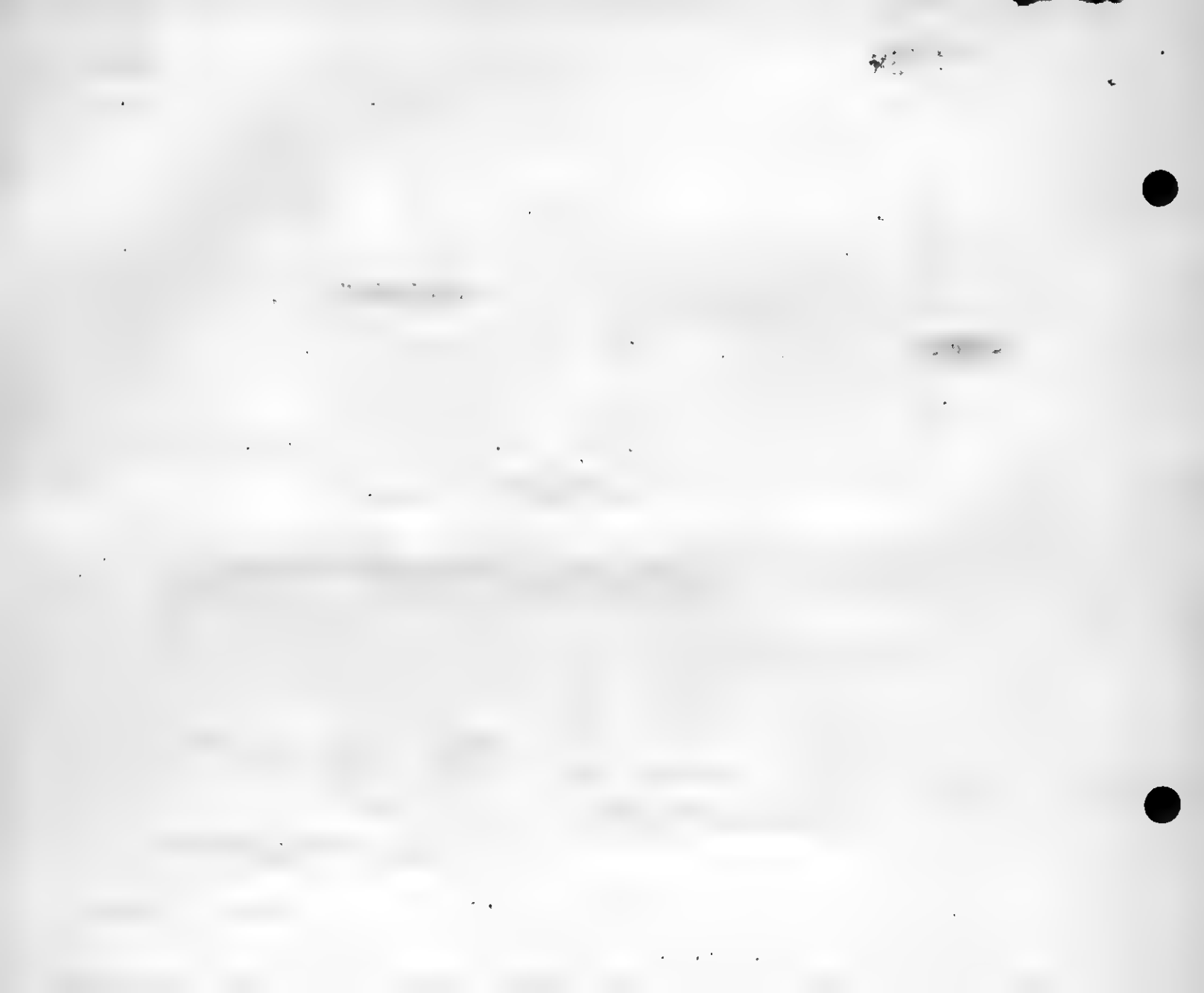
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY                                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Caton Ridge Nursing Home</b>  |  | e. STREET ADDRESS<br><b>4603 Manordenne Road</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>CLARENCE E. GANNON</b>  |  | 4 DATE OF DEATH <b>January 22, 1967</b>   |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-23-1875</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO<br><b>216-05-7494</b>  |   |
| 17. INFORMANT<br><b>Mrs. Elizabeth C. Reed, 4603 Manordene Rd.</b>   |  | Address   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b><br>DUE TO <b>260X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b><br>(c) <b>Diabetic Mellitus</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1967</b> to <b>1/22/1967</b> that (I) (we) lost saw the deceased alive on <b>12/12/1966</b> and that death occurred at <b>5:12 P.M.</b> from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>Dr. Cliff Ratliff, Jr.</b>  |  | 22b. DATE SIGNED<br><b>1/23/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Cliff Ratliff, Jr.</b>  |  | 22d. ADDRESS<br><b>4605 Edmondson Avenue, Balto., Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-24-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 26 1967</b>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|---|--|--|------------------------------|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| 00268   |  |  |  |  |  | 00270   |  |  |                              |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  |  |                              |  |  |  |  |  |  |  |  |
| a. COUNTY   |  |  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |  |  | a. STATE  |  |  | b. COUNTY                    |  |  |  |  |  |  |  |  |
| Baltimore   |  |  | Jawson   |  |  | md 21117  |  |  | Baltimore                    |  |  |  |  |  |  |  |  |
| c. LENGTH OF STAY IN 1b   |  |  | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)     |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)      |  |  | d. STREET ADDRESS            |  |  |  |  |  |  |  |  |
|   |  |  | Dulaney-Jawson Nursing Home  |  |  | Owings Mills  |  |  | Caveswood Lane               |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |  | 4. DATE OF DEATH   |  |  | 5. IS RESIDENCE ON A FARM?  |  |  | 6. IS RESIDENCE ON A FARM?   |  |  |  |  |  |  |  |  |
| First Middle Last   |  |  | Month Day Year   |  |  | YES NO  |  |  | YES NO                       |  |  |  |  |  |  |  |  |
| William A Gaynor  |  |  | 1 23 1967  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| 5. SEX  |  |  | 6. COLOR OR RACE   |  |  | 7. MARRIED  |  |  | 8. DATE OF BIRTH             |  |  |  |  |  |  |  |  |
| male  |  |  | white  |  |  | NEVER MARRIED   |  |  | 87 yrs.                      |  |  |  |  |  |  |  |  |
|   |  |  | WIDOWED  |  |  | DIVORCED  |  |  |                              |  |  |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  | 11. BIRTHPLACE (County & State, or foreign country)                                   |  |  | 12. CITIZEN OF WHAT COUNTRY? |  |  |  |  |  |  |  |  |
| Shoe factory  |  |  | Shoes  |  |  | Baltimore   |  |  | USA                          |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |                              |  |  |  |  |  |  |  |  |
| Meyer Goldberg  |  |  |  |  |  | Ida ?   |  |  |                              |  |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |  |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |                              |  |  | 17. INFORMANT Address  |  |  |  |  |  |
| No  |  |  |  |  |  | 217-01-9667   |  |  |                              |  |  | Mr. Emanuel A. Gaynor, Caveswood Lane,   |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |  |  |  |  |   |  |  |                              |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  |  |  |  |  |  |   |  |  |                              |  |  | 2 days   |  |  |  |  |  |
| 357X DUE TO   |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| DUE TO  |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| Swere general + cerebral arteriosclerosis   |  |  |  |  |  |   |  |  |                              |  |  | 2 yrs.   |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  |  |  |   |  |  |                              |  |  | 19. WAS AUTOPSY PERFORMED?   |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |                              |  |  | YES NO   |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |   |  |  |                              |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.   |  |  |  |  |  |   |  |  |                              |  |  | 20d. INJURY OCCURRED While at work Not While at work   |  |  |  |  |  |
| 19  |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  |  |   |  |  |                              |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from Aug 1966, to Jan 23, 1967, that (I) (we) last saw the deceased alive on Jan 19 1967, and that death occurred at 7:15 M, from the causes and on the date stated above. |  |  |  |  |  |   |  |  |                              |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE  |  |  |  |  |  |   |  |  |                              |  |  | 22b. DATE SIGNED   |  |  |  |  |  |
| James E. Cohen M.D.   |  |  |  |  |  |   |  |  |                              |  |  | 1/23/67  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  |  |  |  |   |  |  |                              |  |  | 22d. ADDRESS   |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |                              |  |  | 670 v Park Heights Ave. BALTO. Md.   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |  |  |  |  |   |  |  |                              |  |  | 23b. DATE THEREOF  |  |  |  |  |  |
| Burial  |  |  |  |  |  |   |  |  |                              |  |  | 1/25/67  |  |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY  |  |  |  |  |  |   |  |  |                              |  |  | 23d. LOCATION (City, town or county) (State)   |  |  |  |  |  |
| Hebrew Friendship   |  |  |  |  |  |   |  |  |                              |  |  | Baltimore, Maryland  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR ADDRESS  |  |  |  |  |  |   |  |  |                              |  |  | 25a. REC'D BY REGISTRAR  |  |  |  |  |  |
| Sol Levinson & Bros. Inc., 6010 Reisterstown  |  |  |  |  |  |   |  |  |                              |  |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |  |  |
|   |  |  |  |  |  |   |  |  |                              |  |  | J Charles Judge  |  |  |  |  |  |
| DATE  |  |  |  |  |  |   |  |  |                              |  |  | JAN 30 1967  |  |  |  |  |  |





00269

## CERTIFICATE OF DEATH

00271

|   |  |  |   |
|---|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b><br>c. LENGTH OF STAY IN 1b  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Washington</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Old Pimlico Road</b>  |  | d. STREET ADDRESS <b>Old Pimlico Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print) <b>WALTER T. GEARY</b><br>First Middle Last   |  | 4. DATE OF DEATH <b>January 10 1967</b><br>Month Day Year  |   |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>Aug. 15, 1883</b><br>9. AGE (In years last birthday) <b>83</b> yrs                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Meats</b>   | 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>John Geary</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Mary O'Day</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO <b>218-32-3829</b>  |   |
| 17. INFORMANT <b>Howard W. Geary</b>  |  | Address <b>Old Pimlico Road</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Atherosclerosis, generalized</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dilated Cardiomyopathy</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1955</b> , 19 to <b>Jan</b> , 19 <b>67</b> , that (I) (we) lost the deceased alive on <b>Jan 10 1967</b> , and that death occurred at <b>IP</b> M. from causes and on the date stated above  |  |  |   |
| 22a. SIGNATURE <b>William G. Helfrich</b>   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   | 22b. DATE SIGNED <b>1-10-67</b>   |
| 22c. PHYSICIAN'S NAME (Type) <b>William G. Helfrich, M.D.</b>   |  | 22d. ADDRESS <b>5006 Roland av. Balto Md</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>1/13/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>   |
| 24. FUNERAL DIRECTOR ADDRESS <b>Ullrich Funeral Home 4210 Belair Road.</b>  |  | 25a. REC'D BY REGISTRAR <b>JAN 12 1967</b>   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00270

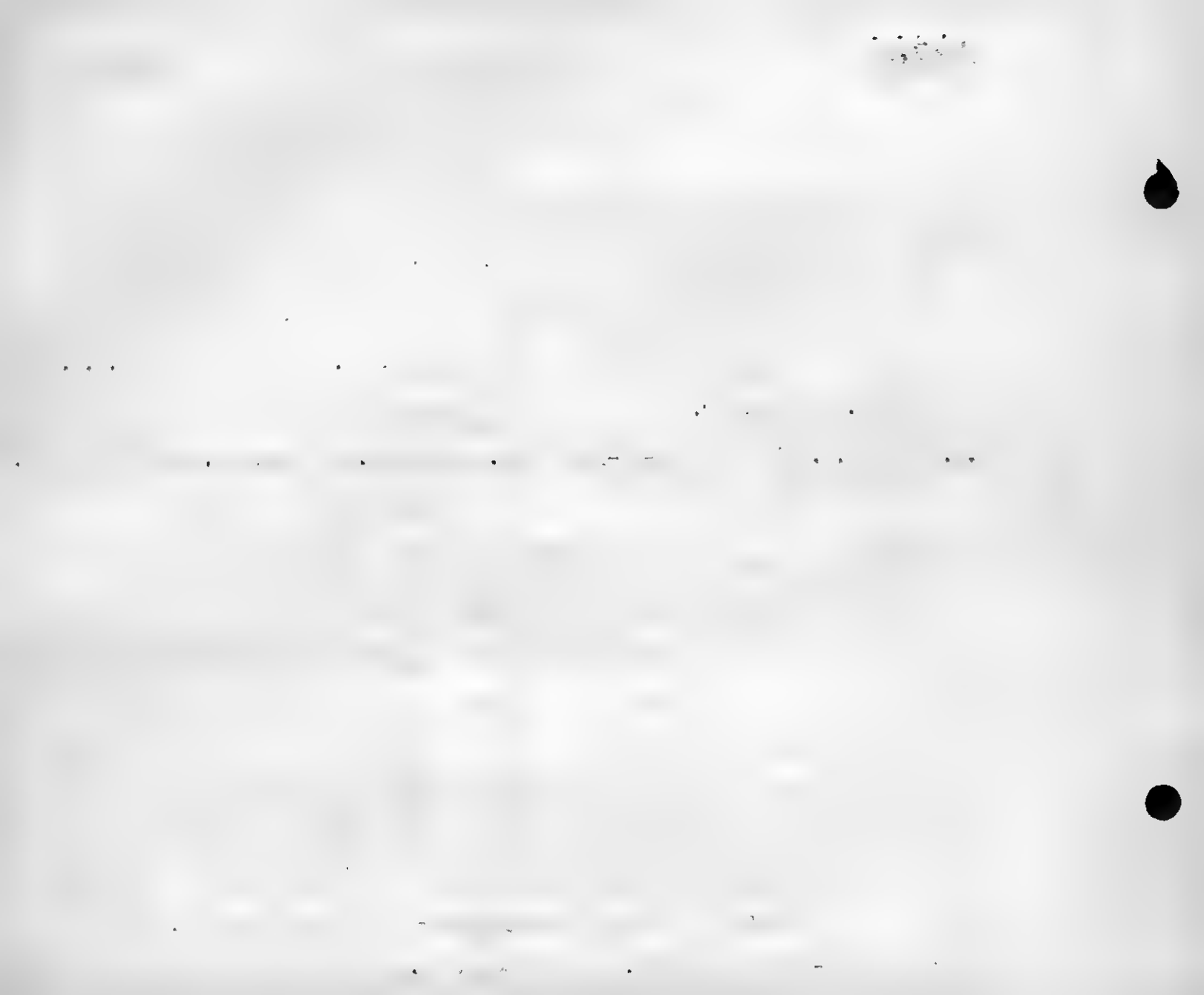
## CERTIFICATE OF DEATH

00272

|   |                               |  |                                |
|---|-------------------------------|--|--------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>30.4</u>                         |                                |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adamsville</u>  |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |                                |
| c. LENGTH OF STAY IN 1b   |                               | d. STREET ADDRESS <u>4114 Neoborn Ave</u>  |                                |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto County General Hosp.</u>  |                               | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                |
| 3 NAME OF DECEASED (Type or print)<br>First <u>BENJAMIN</u> Middle <u>S</u> Last <u>GETTINGS</u>  |                               | 4 DATE OF DEATH<br>Month <u>1</u> Day <u>3</u> Year <u>1967</u>  |                                |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>Sp.</u> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-9-02</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs   |                               | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min   |                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Self Employed Poultry</u>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry</u>   |                                |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Richmond, Va.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                |
| 13. FATHER'S NAME <u>William H. Gettings Sr.</u>  |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Crump</u>   |                                |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>W.W. II</u>  |                               | 16. SOCIAL SECURITY NO. <u>218-14-3947</u>   |                                |
| 17. INFORMANT <u>Mr. William H. Gettings Jr.</u>  |                               | Address <u>5402 Clover Rd. 21215</u>   |                                |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO (b) <u>pulmonary edema acute</u><br>DUE TO (c) <u>old myocardial infarction</u>                             |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>9 hrs.</u><br><u>3 hrs.</u><br><u>1 yr.</u>   |                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o m. p.m. <u>19</u>  |                               | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  |                                |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>67</u> , to <u>1-3</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>1-3</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> M, from causes and on the date stated above. |                               |  |                                |
| 22a. SIGNATURE <u>Charles Judge</u>   |                               | 22b. DATE SIGNED <u>1/3/67</u>   |                                |
| 22c. PHYSICIAN'S NAME (Type) <u>Balto. County Gen. Hosp.</u>  |                               | 22d. ADDRESS   |                                |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>1/6/67</u>  |                                |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>  |                               | 23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md. 21208</u>   |                                |
| 24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>   |                               | 25a. REC'D BY REGISTRAR <u>JAN 6 1967</u>  |                                |
|   |                               | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                                |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

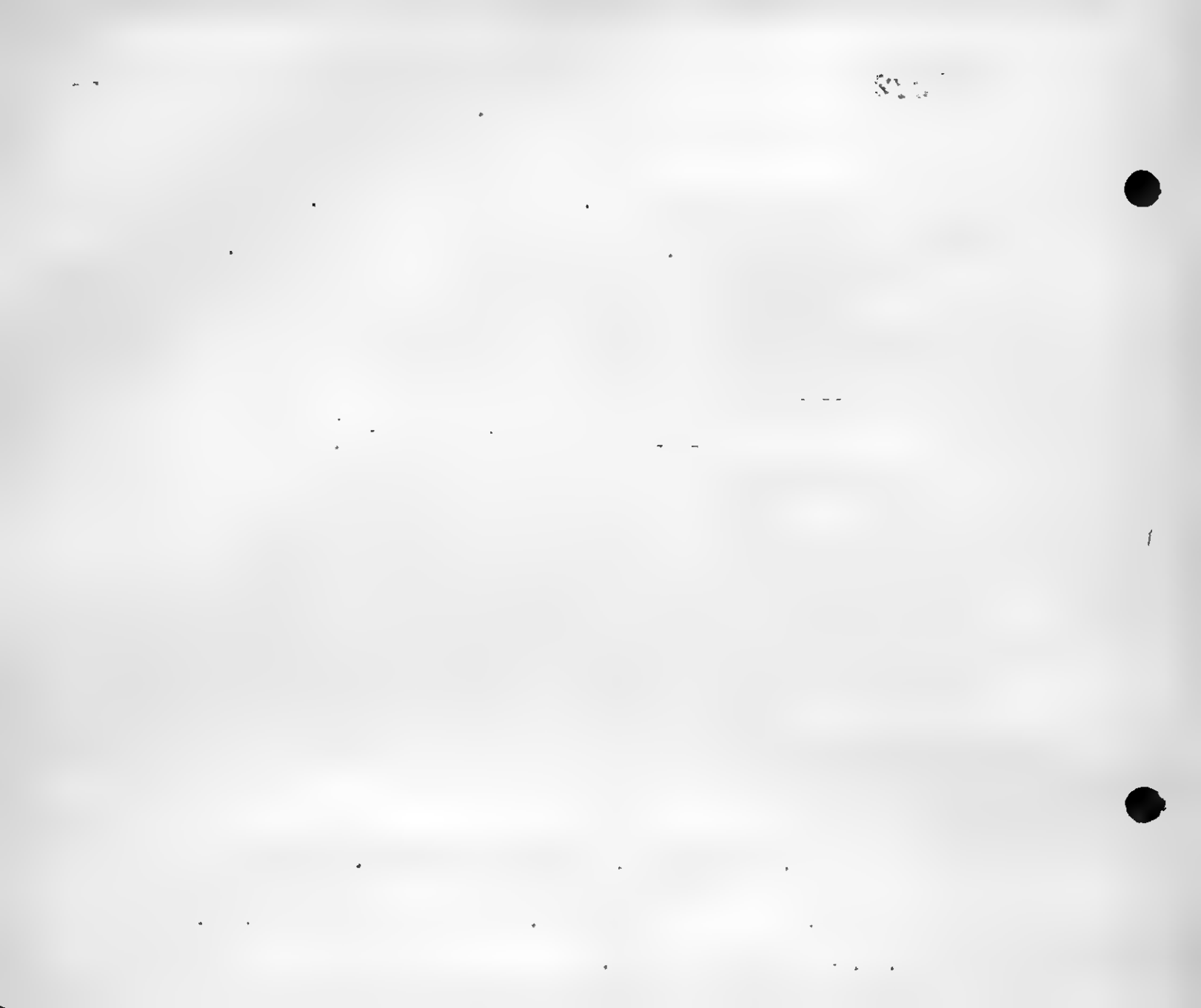
00273

00271

|   |                               |   |                                      |   |  |   |  |
|---|-------------------------------|---|--------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               |   |                                      | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |                               |   |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore - 7</u>                                |  |   |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><u>House in the Pines - Catonsville, Md.</u>  |                               |   |                                      | d. STREET ADDRESS<br><u>1451 Langford Rd.</u>   |  |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Hayden</u> Middle <u>P.</u> Last <u>Gill</u>  |                               |   |                                      | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>17</u> Year <u>1967</u>  |  |   |  |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>Wh</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Jan 22/92</u> | 9. AGE (In years last birthday) <u>74</u> yrs.  | IF UNDER 1 YEAR<br>Months <u>12</u> Days <u>05</u> Hours <u>00</u> Min <u>00</u> | IF UNDER 24 HRS.<br>Hours <u>00</u> Min <u>00</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Gill</u>  |                               |   |                                      | 14. MOTHER'S MAIDEN NAME  |  |   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  |                               | 16. SOCIAL SECURITY NO.<br><u>212-07-5842 A</u>   |                                      | INFORMANT<br><u>Mrs. Hayden P. Gill</u><br><u>1451 Langford Rd.</u>   |  | Address<br><u>- #7</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u><br>DUE TO <u>Arteriosclerotic Cardio-Vascular Disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) _____<br>DUE TO (c) _____ |                               |   |                                      |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12mo</u><br><u>103y</u>                                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               |   |                                      |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m.<br><u>19</u>  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I attended the deceased from <u>5-14, 1965</u> to <u>1-17, 1967</u> , that I last saw the deceased alive on <u>1-15, 1967</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>1/19/67</u>  |                               |   |                                      |   |  |   |  |
| ACTUAL SIGNATURE <u>Wilmer K. Gallagher, Sr.</u> M.D.   |                               |   |                                      | PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher, Sr. - 6209 Frederick Ave. Balt. 21228 Md.</u>   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                               | 22b. DATE THEREOF<br><u>1-20-67</u>   |                                      | 22c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cem.</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>                            |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><u>Witzke F. D. - 4101 Edmondson Ave.</u>   |                               |   |                                      | 24a. REC'D BY REGISTRAR<br>DATE <u>JAN 18 1967</u>  |  | 24b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00272

## CERTIFICATE OF DEATH

00274

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution an residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>214</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Summit Nursing Home</b>  |  | d. STREET ADDRESS<br><b>1305 - Wildwood Parkway</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>MARY GOHEEN</b>  |  | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>11</b> Year <b>1967</b>   |  |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>11/5/1879</b>                                |
| 9. AGE (In years last birthday) <b>87</b> yrs   |  | 10. IF UNDER 1 YEAR: Months <b>3</b> Days <b>26</b> Hours <b>1</b> Min <b>0</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>-</b>  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>W. Va.</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Charles Roderick</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Harriet Gibson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>Miss Mildred Goheen (above address)</b>  |  |
| 17. INFORMANT<br><b>Miss Mildred Goheen (above address)</b>   |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br><b>260X</b> IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b><br>DUE TO <b>General Arteriosclerosis</b><br>(b) <b>Diabetes Mellitus</b><br>(c) <b>7 years</b>     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 days</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)   | 20f. (City or town) (County) (State)                               |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1939</b> , 19 <b>Jan 11</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>Jan 11</b> 19 <b>67</b> , and that death occurred at <b>3 P.M.</b> from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE<br><b>Dr. D.P. Alagia</b>  |  | 22b. DATE SIGNED<br><b>1/12/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. D.P. Alagia</b>  |  | 22d. ADDRESS<br><b>305 Frederick Ave, Catonsville, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/14/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Wash. D.C.</b> |
| 24. FUNERAL DIRECTOR<br><b>Nalley's Funeral Home Inc.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 16 1967</b>  |  |
| ADDRESS <b>Mt. Rainier, Maryland</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





00273

## CERTIFICATE OF DEATH

00275

|  |                                 |  |  |
|--|---------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                     |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>   |                                 | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3131 Acton Road</b>   |                                 | d. STREET ADDRESS<br><b>3131 Acton Road</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>H.</b> Last <b>Good</b>   |                                 | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>11</b> Year <b>1967</b>  |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8. DATE OF BIRTH<br><b>December 12, 1904</b> |
| 9 AGE (In years last birthday) yrs <b>62</b>   |                                 | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Co.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>West Virginia</b>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>William Good</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Josephine McGinnes</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                 | 16. SOCIAL SECURITY NO<br><b>213-07-0300</b>   |  |
| 17. INFORMANT<br><b>Mrs. Edna D. Good</b>  |                                 | Address<br><b>(Same)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>260X Elizabetha mellitus</b><br>DUE TO <b>Cerebral arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>None</b> |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 1/2 yrs</b><br><b>2 1/2 yrs</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>March 19 42</b> to <b>Jan. 13 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 10 1967</b> , and that death occurred at <b>11:00 PM</b> , from causes and on the date stated above   |                                 |  |  |
| 22a. SIGNATURE<br><b>A. M. Bacon</b>   |                                 | 22b. DATE SIGNED<br><b>1/13/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>A. M. BACON</b>   |                                 | 22d. ADDRESS<br><b>2810 Taylor Ave.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Cremation</b>  |                                 | 23b. DATE THEREOF<br><b>1/16/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>  |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. # 21214</b>  |                                 | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 13 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                 |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They must be removed carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT

00274

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00276

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. ~~Page 5~~ may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>York</b>  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkton</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Stewartstown</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Baltimore - Harrisburg Expressway</b>  |   | d. STREET ADDRESS<br><b>Mill Street</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>WILLIAM C. GRAFTON</b>  |   | 4. DATE OF DEATH (Found)<br>Month <b>January</b> Day <b>23</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Male</b>   | 6. CO. OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>March 22, 1900</b>                                    |
| 9. AGE (in years last birthday)<br><b>66</b> yrs  |   | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>                           |  |
| 10a. US. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Painting</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Harford Co., Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>John H. Grafton</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Fletcher</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO<br><b>220-22-0032</b>   |  |
| 17. INFORMANT<br><b>Mary E. Grafton</b>   |   | Address <b>Mill Street Stewartstown, Pa.</b>   |  |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE <i>Charles S. Petty</i> M.D.   |   | 22. DATE SIGNED <b>1/24/67</b>   |  |
| EXAMINER'S NAME (Type) <b>Charles S. Petty</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/26/1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>William Watters</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Cooptown Harford Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Charles E. Kurtz Jarrettsville, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 27 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                           |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |   |   |   |  |  |  |   |
|---|--|----------------------------------|---|---|---|--|--|--|---|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |   |   |   |  |  |  |   |
| 00275   |  |                                  | CERTIFICATE OF DEATH  |   |   |  | 00277  |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore County</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>504 Alleghany Avenue</u>   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u><br>d. STREET ADDRESS <u>504 Alleghany Avenue</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Muriel S.</u> Middle <u>Towers</u> Last <u>Grason</u>   |  |                                  |   |   | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>25</u> Year <u>1967</u>   |  |  |  |   |
| 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>white</u>    |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><u>Sept. 6, 1881</u>                                 |  | 9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>  |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>   |   | 11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u> |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |   |
| 13. FATHER'S NAME <u>W.H. Powers</u>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME <u>Louisa Sheffey</u>  |  |  |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  |                                  |   | 16. SOCIAL SECURITY NO. <u>none</u>   |   | 17. INFORMANT <u>Family records</u> Address                              |  |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u><br>DUE TO (b) <u>GENERALIZED ARTERIO SCLEROSIS</u><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |   |   |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>APR. 2 WEEKS</u> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)         |  |   |
| 21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>March 24, 1955</u> to <u>JAN 25, 1967</u> , that (I) <u>had</u> last saw the deceased alive on <u>JAN 24, 1967</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.  |  |                                  |   |   |   |  |  |  |   |
| 22a. SIGNATURE <u>T. C. Siwinski</u>  |  |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <u>Jan. 26, 1967</u>        |  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>T. C. Siwinski, M.D.</u>  |  |                                  |   |   | 22d. ADDRESS <u>206 W. Pennsylvania Ave., Towson, Md.</u>   |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  | 23b. DATE THEREOF <u>1/28/67</u> |   | 23c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>  |   | 23d. LOCATION (City, town or county) (State) <u>Towson, Md. 21204</u>    |  |  |   |
| 24. FUNERAL DIRECTOR <u>John Burns Sons 610-12 York Road Towson</u> ADDRESS   |  |                                  |   |   | 25a. REC'D BY REGISTRAR <u>JAN 31 1967</u> DATE   |  | 25b. REGISTRAR'S SIGNATURE <u>John Burns</u> |  |   |



CERTIFICATE OF DEATH

00276

00278

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u> |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GARRISON</u>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PIKESVILLE</u>                                  |  |
| c. LENGTH OF STAY IN 1b <u>9mo + 5days</u>   |   | d. STREET ADDRESS <u>726 HOWARD RD</u>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FOXLEIGH NURSING HOME</u>  |   | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                      |  |
| 3. NAME OF DECEASED (Type or print) <u>Sophia</u>  | First Middle Last   | 4. DATE OF DEATH <u>Jan 4 1967</u>  | Month Day Year   |
| 5. SEX <u>FEMALE</u>   | 6. COLOR OR RACE <u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>3-9-1892</u>              | 9. AGE (In years last birthday) <u>74</u> yrs.                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)   | 12. CITIZEN OF WHAT COUNTRY?                                       |
| 13. FATHER'S NAME <u>ROSEWELL W GRAVES</u>   | 14. MOTHER'S MAIDEN NAME <u>SOPHIA L WYATT</u>  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>  | 16. SOCIAL SECURITY NO. <u>None</u>   | 17. INFORMANT <u>William R Wyatt, 15107 Document Ave. The.</u> Address <u>Baltimore 21204</u>                                       |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>251X</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO<br>Cerebral vascular accident & rt hemiplegia |   | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                               |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>4 Jan 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>3 Jan 1967</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.                    |   |   |  |
| 22a. SIGNATURE <u>Paul Royce</u>   |   | 22b. DATE SIGNED <u>Jan 4, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>PAUL L ROYCE</u>   |   | 22d. ADDRESS <u>1403 Foley Ln Pikesville MD 21208</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  | 23b. DATE THEREOF <u>January 6, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Thomas Cemetery</u>   | 23d. LOCATION (City, town or county) (State) <u>Pikesville, MD</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank R. Howell</u>  |   | 25a. REC'D BY REGISTRAR <u>Jan 10 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Wm. J. Judge</u>   |  |

24 hours after death. Page 1 of 1. ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 1 of 1. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100





00277

## CERTIFICATE OF DEATH

00279

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>New York</u>              |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Luxemburg</u>  |  |  |  | c. LENGTH OF STAY IN 1b<br><u>11/11/11</u> New York  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>College Manor Nursing Home</u>   |  |  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br><u>Bessie</u> First Middle Last  |  |  |  | 4. DATE OF DEATH<br><u>GRAY</u> Month Day Year <u>1</u> <u>29</u> <u>1967</u>  |  |  |  |
| 5. SEX<br><u>female</u>   |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>July 25, 1877</u>   |  |
| 9. AGE (In years, last birthday)<br><u>89</u> yrs   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Practical Nurse - self</u> |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Nursing</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?  |  |  |  | 13. FATHER'S NAME<br><u>Amasie Dunlap</u>  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Katherine Thompson</u>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u> <u>None</u>                         |  |  |  |
| 16. SOCIAL SECURITY NO.<br><u>120-18-3881</u>   |  |  |  | 17. INFORMANT<br><u>Mr. H. Thompson Bosce</u> Address <u>4415 Underwood Rd.</u>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart failure</u><br>DUE TO (b) <u>arteriosclerosis</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 days</u><br><u>4 years</u>                    |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                    |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4/12</u> , 19 <u>61</u> , to <u>1/29</u> , 19 <u>67</u> ; that (I) (we) last saw the deceased alive on <u>1/28</u> , 19 <u>67</u> , and that death occurred at <u>10 A</u> M, from causes and on the date stated above.                        |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><u>William F. Fritz</u>   |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                     |  | 22b. DATE SIGNED<br><u>1/30/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>William F. Fritz, M.D.</u>   |  |  |  | 22d. ADDRESS<br><u>2 West University Pkwy, Balto. 21218</u>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>1/31/67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Greenmount</u>  |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore Md.</u>                  |  |
| 24. FUNERAL DIRECTOR<br><u>William J. Zickner &amp; Sons North &amp; Penna</u>  |  |  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 2 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

00278

00280

|   |   |  |  |
|---|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Reside before admission)<br>a STATE <b>MARYLAND</b> b COUNTY <b>ANNE ARUNDEL</b>                   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |   | c LENGTH OF STAY IN 1b<br><b>61 DAYS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>CROWNSVILLE</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>JOSEPH</b> Middle <b>WILLIAM</b> Last <b>GRAY</b>  |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>11</b> Year <b>1967</b>  |  |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>NEGRO</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>OCT. 29, 1914</b>  |
| 9 AGE (In years last birthday)<br><b>52</b> yrs   |   | 10 IF UNDER 1 YEAR<br>Months <b>52</b> Days <b>52</b> Hours <b>52</b> Min <b>52</b>  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FARMER</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>FARM</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>LOTHIAN, MARYLAND</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>GEORGE GRAY</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>MARY WHITTINGTON</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>   |   | 16 SOCIAL SECURITY NO.<br><b>218 12 90 37</b>  |  |
| 17 INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |   | Address  |  |
| 18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>SQUAMOUS CELL CARCINOMA OF LUNG WITH METASTASIS</b><br>DUE TO (b) _____<br>CUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |
| PART II OTHER SIGNIFKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)  |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)  | 20f. (City or town) (County) (State)   |
| 21 I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/11/66</b> , 19____, to <b>1/11/67</b> , 19____, that <del>he</del> (we) lost saw the deceased alive on <b>1/11/67</b> , 19____, and that death occurred at <b>9:00 PM</b> , from causes and on the date stated above     |   |  |  |
| 22a SIGNATURE<br><i>Peter Juvan</i>   |   | 22b. DATE SIGNED<br><b>1/12/67</b>   |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>PETER JUWAN, M. D.</b>  |   | 22d ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b DATE THEREOF<br><b>1-15-1967</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>LOTHIAN CEMETERY</b>   | 23d LOCATION (City or Town) (County) (State)<br><b>LOTHIAN, MARYLAND</b>                         |
| 24 FUNERAL DIRECTOR<br><i>William Reesett</i>   |   | 25a REC'D BY REGISTRAR<br><b>REESSE FUNERAL HOME</b>   |  |
| 25b REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |   | DATE <b>JAN 16 1967</b><br><b>WASHINGTON ST. ANNAPOLIS, MD.</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



00279

## CERTIFICATE OF DEATH

00281

|  |                                 |  |                                     |
|--|---------------------------------|--|-------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                    |                                     |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Woodlawn</b>  |                                 | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>  |                                     |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2707 Gwynnmore Avenue</b>   |                                 | d. STREET ADDRESS<br><b>2707 Gwynnmore Avenue</b>  |                                     |
| 3 NAME OF DECEASED (Type or print)<br><b>Charles Edward Grewe</b>  |                                 | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>26</b> Year <b>19 67</b>  |                                     |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 8 DATE OF BIRTH<br><b>2-13-1899</b> |
| 9. AGE (In years last birthday)<br><b>67</b> yrs   |                                 | IF UNDER 1 YEAR<br>Months Days Hours Min   |                                     |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Tool &amp; Die Specialist</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore</b>  |                                     |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore</b>   |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                     |
| 13 FATHER'S NAME<br><b>Louis Grewe</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth</b>   |                                     |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                 | 16. SOCIAL SECURITY NO.<br><b>216-03-4259</b>  |                                     |
| 17. INFORMANT<br><b>Muriel O. Grewe</b>  |                                 | Address<br><b>2707 Gwynnmore Ave.</b>  |                                     |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Lung Rt.</b><br>DUE TO (b) <b>Arterio Sclerotic Heart Disease</b><br>DUE TO (c) <b>10 yrs</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                 |  |                                     |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>   |                                 |  |                                     |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                 |  |                                     |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                 |  |                                     |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                     |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                 | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |                                     |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 17</b> , 19 <b>66</b> , to <b>Jan 26</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/26</b> , 19 <b>67</b> , and that death occurred at <b>7 P.</b> M, from causes and on the date stated above.  |                                 |  |                                     |
| 22a. SIGNATURE<br><b>Earl L. Chambers</b>  |                                 | 22b. DATE SIGNED<br><b>1/27/67</b>   |                                     |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Earl L. Chambers</b>  |                                 | 22d. ADDRESS<br><b>4108 Liberty Hts Baltimore, Md</b>  |                                     |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 23b. DATE THEREOF<br><b>1-30-1967</b>  |                                     |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Cemetery</b>   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>  |                                     |
| 24. FUNERAL DIRECTOR<br><b>Ellsworth Amato</b>   |                                 | ADDRESS<br><b>4600 Liberty Hghts. Avenue</b>   |                                     |
| 25a. REC'D BY REGISTRAR<br><b>JAN 30 1967</b>  |                                 | 25b. REGISTRAR'S SIGNATURE<br><b>William Judge</b>   |                                     |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2012



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

00280

00282

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                     |   |  |
|--|-------------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |                                     | 2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>         |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |                                     | c. LENGTH OF STAY IN It<br><b>5 Years</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>2005 Frames Road</b>  |                                     | e. STREET ADDRESS<br><b>2005 Frames Road</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Laurie Elmer Griffin</b>   |                                     | 4 DATE OF DEATH<br>Month Day Year<br><b>January 12, 1967</b>  |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>     | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>6/22/90</b>  |
| 9 AGE (In years last birthday)<br><b>76</b> yrs  |                                     | 10 IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer, retired</b>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11 BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>  |                                     | 12 CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13 FATHER'S NAME<br><b>Jim Griffin</b>   |                                     | 14 MOTHER'S MAIDEN NAME<br><b>Elizabeth Griffin</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                     | 16 SOCIAL SECURITY NO<br><b>237-28-8158</b>   |  |
| 17 INFORMANT (Son)<br><b>James Griffin</b>   |                                     | Address<br><b>21224 1420 Bonsol St. Balto. Md.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>42a.1 IMMEDIATE CAUSE (a) AS-C-V-DISEASE</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) DUE TO  |                                     |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NONE</b>   |                                     |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                                     | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not White <input type="checkbox"/><br>of work of work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)  |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                     |   |  |
| ACTUAL SIGNATURE<br><b>M B Davis</b>   |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Melvin B. Davis</b>   |                                     | M.D.  |  |
| 22. DATE SIGNED<br><b>1/13/67</b>  |                                     | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Dundalk, Md.</b><br>Address (Street, city, town or county)<br><b>6800 Morningside Rd.</b>    |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/15/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosebud Christian Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Walnut Cove, N. C.</b>                       |
| 24 FUNERAL DIRECTOR<br><b>John J. Duda</b>   |                                     | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>   |  |
| 25a. RECD BY REGISTRAR<br><b>J Charles Judge</b>   |                                     | 25b. REGISTRAR'S SIGNATURE<br><b>J Charles Judge</b>  |  |

1999





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00281

CERTIFICATE OF DEATH

00283

|  |  |   |   |
|--|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if not institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>13.1</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Summit Nursing Home</b>   |  | d. STREET ADDRESS<br><b>1310 Poplar Avenue</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <b>MARIE C. GROSS</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>4</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-21-1879</b>                                       |
| 9. AGE (in years last birthday)<br><b>87</b> yrs   |  | 10. IF UNDER 1 YEAR<br>Months <b>8</b> Days <b>7</b> Hours <b>19</b> Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>George Alheit</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Agnes Albright</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mrs. Edna Button, 1310 Poplar Ave. 21227</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>331X</b> IMMEDIATE CAUSE (a) <b>C.U.A.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <b>Generalized Arteriosclerosis</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 wks</b>  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Nov 24, 1966</b> to <b>Jan 4, 1967</b> that (I) (we) last saw the deceased alive on <b>Dec 24, 1966</b> and that death occurred at <b>3:00 AM</b> from causes and on the date stated above  |  |   |   |
| 22a. SIGNATURE<br><b>Earl I. Pass M.D.</b>   |  | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Dr. Earl I. Pass</b>   |  | 22d. ADDRESS<br><b>4001 Wilkens Ave, Balto., Md. 21229</b>  |   |
| 23a. BURIAL, CREMATION REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>XXX 1-7-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 9 1967</b>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |



FOR STATE  
HEALTH DEPT.

00282

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00284

|   |                                  |  |  |
|---|----------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore Rural</b>  |                                  | c. LENGTH OF STAY in 1b<br><b>Baltimore Rural (DUNDALK)</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>34 Yorkway</b>   |                                  | d. STREET ADDRESS<br><b>34 Yorkway</b>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>FRANCES M/ HABICHT</b>   |                                  | 4 DATE OF DEATH<br>Month Day Year<br><b>January 14 19 67</b>   |  |
| 5 SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>August 25, 1909</b> |
| 9 AGE (In years last birthday)<br><b>57 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>19 67</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At home</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                                  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13 FATHER'S NAME<br><b>Frank Urbancik</b>   |                                  | 14 MOTHER'S MAIDEN NAME<br><b>Mary Shrachovec</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16 SOCIAL SECURITY NO.<br><b>213-05-3520</b>   |  |
| 17 INFORMANT<br><b>Carl W. Habicht</b>  |                                  | Address<br><b>34 Yorkway 21222</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Compression of Cervical Spinal Cord</b><br>DUE TO<br>(b) <b>Fracture of Cervical Vertebra, C4.</b><br>DUE TO<br>(c) <b>4000</b><br>Condition: if any, which gave rise to immediate cause (a) stating the underlying cause lost.   |                                  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Fall down steps</b>   |                                  |  |  |
| 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>Fall down steps</b>                                      |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour <del>XXXX</del> <b>1/14 1967</b><br>pm  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/><br>of work of work                                       |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)<br><b>Home</b>  |                                  | 20f. (City or town) (County) (State)<br><b>Baltimore Md.</b>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                  |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b>   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>Charles S. Petty</b>   |                                  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>   |  |
| 22. DATE SIGNED<br><b>1/15/67</b>   |                                  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |  |
| Address (Street, city, town, or county)   |                                  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1/18/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Co., Md.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Ullrich Funeral Home Dundalk, Md.</b>  |                                  | ADDRESS  |  |
| 25a. REC'D BY REGISTRAR<br><b>JAN 15 1967</b>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Judge</b>   |  |

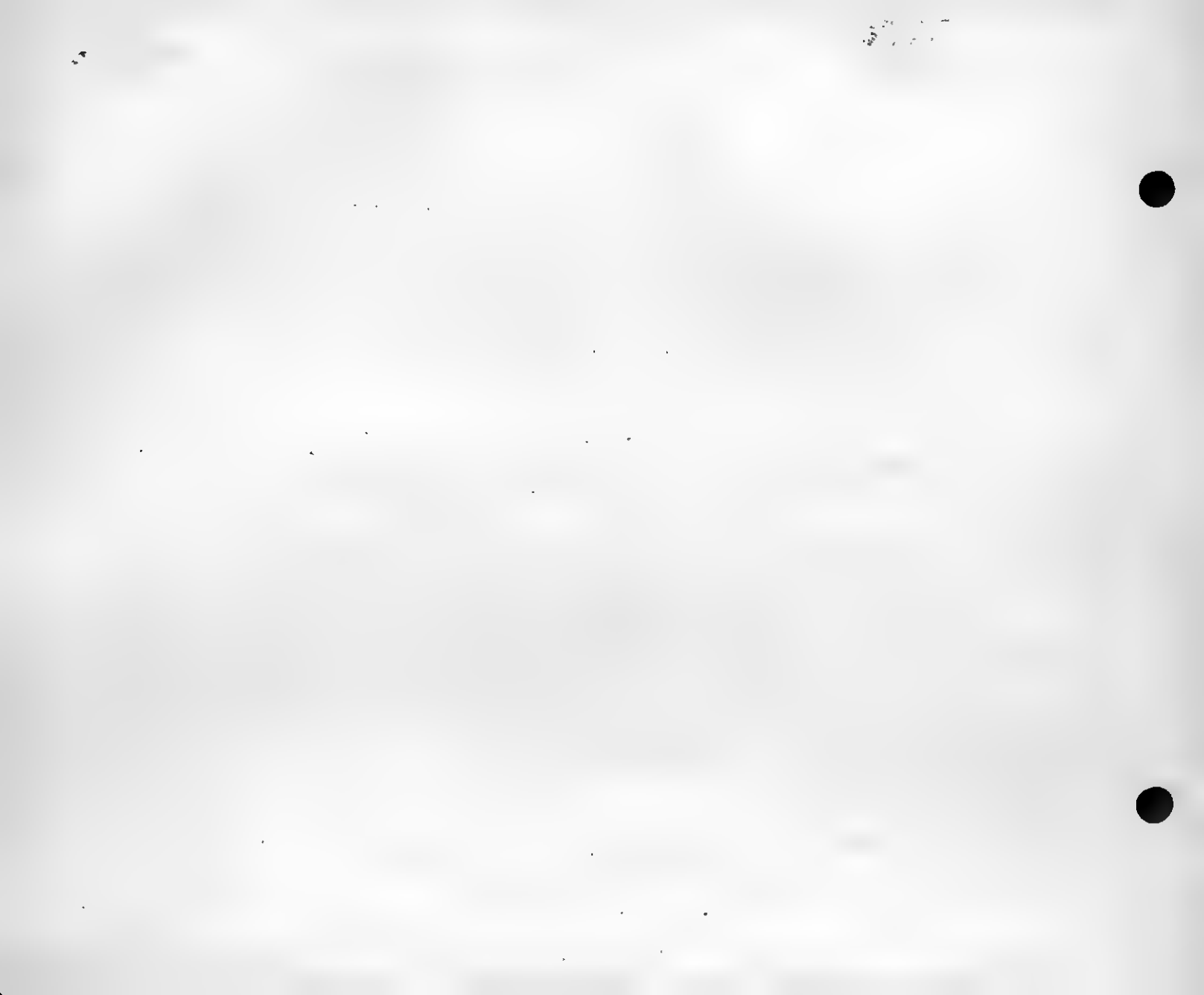
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1925

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                           |  |  |  |   |  |  |  |   |  |
|---|--|---------------------------|--|--|--|---|--|--|--|---|--|
| 00283   |  |                           |  |  |  | 00285   |  |  |  |   |  |
| 1. PLACE OF DEATH   |  |                           |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                             |  |  |  |   |  |
| a. COUNTY <u>BALTO.</u> MARYLAND  |  |                           |  |  |  | a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>  |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u>  |  |                           |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u> <u>13.</u> |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>309 LOCUST DRIVE</u>   |  |                           |  |  |  | d. STREET ADDRESS<br><u>309 LOCUST DRIVE</u>  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print)   |  |                           |  |  |  | 4. DATE OF DEATH  |  |  |  |   |  |
| First <u>JAMES</u> Middle <u>G.</u> Last <u>HARDY</u>   |  |                           |  |  |  | Month <u>JAN.</u> Day <u>1</u> Year <u>1967</u>   |  |  |  |   |  |
| 5. SEX <u>M</u>   |  | 6. COLOR OR RACE <u>W</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>APRIL 26, 1920</u>   |  | 9. AGE (In years last birthday)<br><u>46</u> yrs.    |  | IF UNDER 1 YEAR<br>Months Days Hours Min.         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>SET</u>   |  |                           |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>MD. PENITENTARY</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>MD.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?                      |  |
| 13. FATHER'S NAME<br><u>JAMES D. HARDY</u>  |  |                           |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>EMMA BALLADARSH</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><u>YES</u>   |  |                           |  | 16. SOCIAL SECURITY NO.<br><u>212-01-4271</u>  |  | 17. INFORMANT<br><u>Mrs. James J. Hardy - 309 Locust Drive</u>  |  |  |  | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u><br><u>100%</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                           |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 year</u> |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                           |  |  |  |   |  |  |  |   |  |
| MEDICAL CERTIFICATION   |  |                           |  |  |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                           |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |                           |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                 |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 5</u> , 19 <u>64</u> , to <u>Jan 1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 1</u> , 19 <u>67</u> , and that death occurred at <u>49</u> M, from the causes and on the date stated above.  |  |                           |  |  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Kennard Yaffe</u>  |  |                           |  |  |  | 22b. DATE SIGNED<br><u>1/3/67</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>KENNARD YAFFE</u> |  | 22d. ADDRESS<br><u>5501 Forest Park Ave</u>       |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF         |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION (City, town or county) (State)  |  |  |  |   |  |
| <u>Buried</u>   |  | <u>1-4-66</u>             |  | <u>Forest Park Cem.</u>  |  | <u>Balto. Md.</u>   |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br><u>Forley-Corway &amp; Son</u>  |  |                           |  |  |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |
| ADDRESS<br><u>Catonville, Md.</u>   |  |                           |  |  |  | DATE <u>JAN 6 1967</u>  |  |  |  |   |  |



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses after item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

00284

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00286\*

|   |  |  |   |
|---|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Towson Baltimore</b>   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |   |
| b. CITY OR TOWN (If outside corporate limits, write R.R. and give nearest town)<br><b>Towson</b>  |  | c. LENGTH OF STAY IN IB  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |  | e. STREET ADDRESS<br><b>4 1905 Swansea Rd.</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>Mary Elizabeth Harrell</b>  |  | 4 DATE OF DEATH<br>Month Day Year<br><b>1 14 19 67</b>   |   |
| 5 SEX<br><b>F</b>   | 6 COLOR OR RACE<br><b>W</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>8-28-1913</b>   |
| 9 AGE (in years last birthday) yrs<br><b>53</b>   |  | 10 IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>10 10 10 10</b>  |   |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 12 KIND OF BUSINESS OR INDUSTRY<br><b>North Carolina</b>   |   |
| 13 FATHER'S NAME<br><b>Gary Sullivan</b>  |  | 14 MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16 SOCIAL SECURITY NO.<br><b>214-22-9961</b>   |   |
| 17 INFORMANT<br><b>Mr. Wesley B. Harrell</b>  |  | Address<br><b>(Same)</b>   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a)<br><b>Coronary occlusion</b><br>DUE TO<br><b>Coronary insufficiency</b><br>DUE TO<br><b>5th Month</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5th Month</b>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE<br><b>Charles E. O'Donnell</b> M.D.  |  | 22. DATE SIGNED<br><b>1/14/67.</b>   |   |
| EXAMINER'S NAME (Type)<br><b>CHARLES E. O'DONNELL, M.D.</b>   |  | Address (Street, city, town, or county)  |   |
| 23a BURIAL, CREMATION, REBURY (Type)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>1/18/67.</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Mem. Cemetery</b>   | 23d LOCATION (City or town) (County) (State)<br><b>Eldersburg, Carroll, Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |  | 25a REC'D BY REGISTRAR<br>DATE <b>JAN 18 1967</b>  |   |
| ADDRESS   |  | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

7-10-10

Page 10

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00285

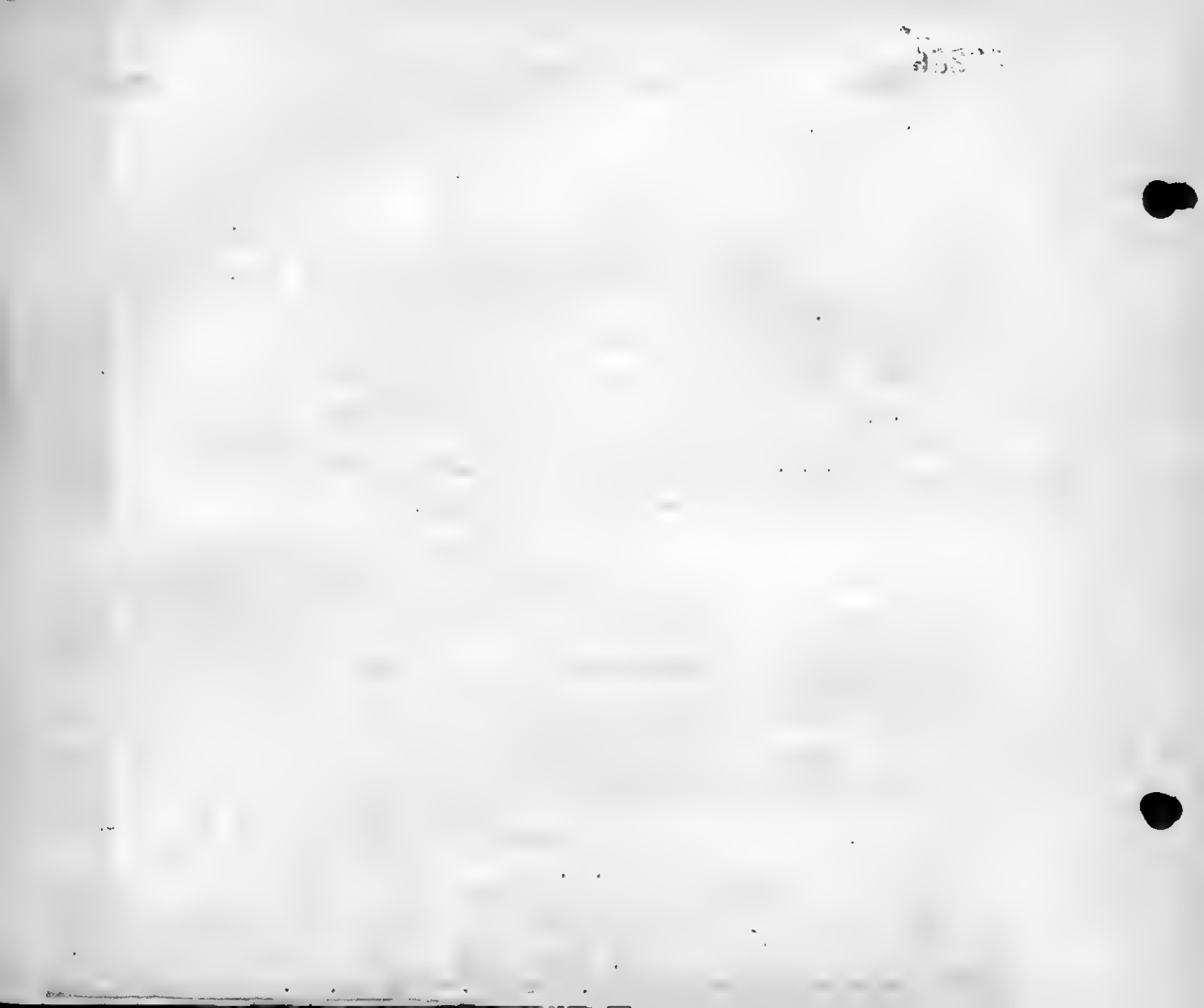
## CERTIFICATE OF DEATH

00287

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY                               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>59 DAYS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                  | d. STREET ADDRESS<br><b>530 SOUTH HANOVER ST.</b>   |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>ABRAHAM</b> Last <b>HART</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>2</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>APRIL 19, 1880</b>          |
| 9. AGE (In years last birthday) <b>86</b> yrs  |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHAUFFEUR</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>FRANKLIN, VIRGINIA</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>JUNIUS HART</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>MINNIE WELLS</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES S.A.W.</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>217 22 91 26</b>   |  |
| 17. INFORMANT<br><b>VA HOSPITAL</b>  |                                  | 18. CLINICAL RECORDS<br><b>FORT HOWARD, MARYLAND</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>157X</b> IMMEDIATE CAUSE (a) <b>CARCINOMA HEAD OF PANCREAS</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____ |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>NOV. 4</b> , 19 <b>66</b> , to <b>JAN. 2</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>JAN. 2</b> , 19 <b>67</b> , and that death occurred on <b>250P.M.</b> from causes and on the date stated above                                |                                  |   |  |
| 22a. SIGNATURE<br><i>Milton Ginsberg</i>   |                                  | 22b. DATE SIGNED<br><b>1/3/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MILTON GINSBERG, M. D.</b>  |                                  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>EASTLAWN</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>WILLIAMSTOWN, MASS.</b>   |  |
| 24. FUNERAL DIRECTOR<br><i>Charles A. Rice</i>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 6 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles A. Rice</i>   |                                  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (see page 1 and 2). Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00286

00288

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY _____                  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  | c. LENGTH OF STAY IN 1b <u>4 mos.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annarest Nurs Home</u><br><u>815 Register Ave.</u>   |  |  |  | d. STREET ADDRESS <u>3333 N. Charles St.</u>   |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Henry S. Hartman</u>  |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>1</u> Day <u>21</u> Year <u>1967</u>   |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>W</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 8. DATE OF BIRTH <u>Mar. 24 1888</u>   |  | 9. AGE (In years last birthday) <u>78</u> yrs  |  | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min _____  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>INVESTMENTS</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>   |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  | 13. FATHER'S NAME <u>Hartman</u>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <u>Esther</u>   |  |  |  | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>  |  |  |  |
| 16. SOCIAL SECURITY NO. <u>None</u>  |  |  |  | 17. INFORMANT <u>Nurs. Home Chart</u> Address _____  |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u><br>DUE TO <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____<br>DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CVA</u> |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a. m. _____ p. m. _____ 19____  |  |  |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) _____ (County) _____ (State) _____   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 31, 1966</u> to <u>Jan 21, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 21, 1967</u> and that death occurred at <u>8 PM</u> from the causes and on the date stated above  |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Daniel V. Lindenstruth</u> M.D.  |  | ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> |  | 22b. DATE SIGNED <u>Jan 21, 1967</u>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Daniel V. Lindenstruth, MD</u>   |  | 22d. ADDRESS <u>7501 York Rd.</u>  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1/24/1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Cemetery Baltimore, Maryland</u>  |  |  |  |
| 23d. LOCATION (City, town, or county) _____ (State) _____  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tubman</u> ADDRESS <u>Baltimore</u>  |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



00288

CERTIFICATE OF DEATH

00290

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or in any event, within 72 hours after death.

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Relay</b><br>c. LENGTH OF STAY IN 1b<br><b>Relay</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>406 Gun Road</b>  |  | 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Relay</b><br>d. STREET ADDRESS<br><b>406 Gun Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>WILLIAM D. GILL HEDEMAN</b><br>First Middle Last  |  | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>19 67</b>   |  |
| 5 SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1-12-1882</b>   |
| 9. AGE (In years last birthday)<br><b>85</b> yrs  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Hedeman</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO<br><b>705-05-7795</b>  |  |
| 17. INFORMANT<br><b>Mrs. Nettie M. Hedeman, 406 Gun Road</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cardiac Failure</b><br>DUE TO <b>Cardio-Vascular</b><br>disease<br>(b) <b>Chronic Inflammation of</b><br>(c) <b>Stomach</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b><br><b>5 yrs</b><br><b>10 yrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 29, 1967</b> to <b>Jan 31, 1967</b> shot (I) (we) saw the deceased alive on <b>Jan 30, 1967</b> , and that death occurred at <b>8:30 A.M.</b> from causes on and on the date stated above  |  |   |  |
| 22a. SIGNATURE<br><b>Dr. Bruce Brumbaugh</b>  |  | 22b. DATE SIGNED<br><b>2/1/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Bruce Brumbaugh</b>  |  | 22d. ADDRESS<br><b>5609 Main Street, Elkridge, Maryland</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>2-2-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>3801 Frederick Ave. Balto. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 3 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                     |



00289

CERTIFICATE OF DEATH

00291

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                              |  |                                       |
|--|------------------------------|--|---------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN 1b <b>10yr7mth23dys</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Point</b><br>d. STREET ADDRESS <b>2112 Oak Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                       |
| 3 NAME OF DECEASED (Type or print) <b>Saimi (Saima) Heikkila</b>   |                              | 4 DATE OF DEATH <b>January 17 19 67</b>  |                                       |
| 5 SEX <b>female</b>  | 6 COLOR OR RACE <b>white</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH <b>March 22, 1893</b> |
| 9 AGE (In years last birthday) <b>73</b> yrs   |                              | 10 UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> Hours <input type="checkbox"/> Min <input type="checkbox"/>  |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY  |                                       |
| 11 BIRTHPLACE (County & State, or foreign country) <b>Finland</b>  |                              | 12. CITIZEN OF WHAT COUNTRY? <b>Finland</b>  |                                       |
| 13. FATHER'S NAME <b>Samuel Setala</b>   |                              | 14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                              | 16 SOCIAL SECURITY NO.   |                                       |
| 17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>  |                              | Address  |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b><br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) <b>Arteriosclerotic cardiovascular heart Dis</b> 5 yrs.<br>DUE TO<br>(c) <b>Arteriosclerosis, Generalized</b> 5 yrs. |                              | INTERVAL BETWEEN ONSET AND DEATH <b>acute</b>  |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Combined mitral stenosis and insufficiency &amp; Pul. Fibrosis</b>  |                              |  |                                       |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                              |  |                                       |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                       |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                              | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                              | 20f (City or town) (County) (State)  |                                       |
| 21. I certify that <del>at</del> (this hospital) attended the deceased from <b>May 24 19 56</b> to <b>Jan. 17, 19 67</b> , that <del>it</del> (we) last saw the deceased alive on <b>Jan. 17 19 67</b> , and that death occurred at <b>10:10</b> M, from causes and on the date stated above.  |                              |  |                                       |
| 22a. SIGNATURE <b>Anthony J. Young, M.D.</b>   |                              | 22b. DATE SIGNED <b>1-17-67</b>  |                                       |
| 22c. PHYSICIAN'S NAME (Type) <b>Anthony J. Young, M.D.</b>   |                              | 22d. ADDRESS <b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>  |                                       |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>  |                              | 23b. DATE THEREOF <b>1/20/67</b>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Yolub Funeral Home, Cleveland, Ohio.</b>   |                              | 23d. LOCATION (City or Town) (County) (State) <b>(Cleveland, Ohio.)</b>  |                                       |
| 24. FUNERAL DIRECTOR ADDRESS   |                              | 25a REC'D BY REGISTRAR DATE <b>JAN 23 1967</b>   |                                       |
|  |                              | 25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |                                       |









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AIS (4)  
ISM 7-62

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                  |  |   |  |   |  |  |                       |  |  |
|--|--|------------------|--|---|--|---|--|--|-----------------------|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                  |  |   |  |   |  |  |                       |  |  |
| 00291  |  |                  |  |   |  | 00293   |  |  |                       |  |  |
| 1. PLACE OF DEATH  |  |                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission)      |  |  |                       |  |  |
| a. COUNTY  |  |                  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |   |  | a. STATE  |  |  | b. COUNTY             |  |  |
| Baltimore  |  |                  | Owings Mills   |   |  | Maryland  |  |  | Baltimore             |  |  |
| c. LENGTH OF STAY IN 1b  |  |                  | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)     |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)            |  |  | d. STREET ADDRESS     |  |  |
| 17 years   |  |                  | 31 Pleasant Hill Road  |   |  | Owings Mills  |  |  | 31 Pleasant Hill Road |  |  |
| 3. NAME OF DECEASED (Type or print)  |  |                  |  |   |  | 4. DATE OF DEATH  |  |  |                       |  |  |
| First  |  | Middle           |  | Last  |  | Month   |  | Day  |                       | Year   |  |
| Eli  |  | Edward           |  | Hewitt  |  | January   |  | 21,  |                       | 1967   |  |
| 5. SEX   |  | 6. COLOR OR RACE |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)  |                       | IF UNDER 1 YEAR                              |  |
| Male   |  | White            |  | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |  | Nov. 23, 1921   |  | 45 yrs.  |                       | Months Days Hours Min.                       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |                  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country)                    |                       |  |  |
| Farmer   |  |                  |  | Poultry Farm  |  |   |  | Glyndon, Bal to. Co., Md.  |                       |  |  |
| 13. FATHER'S NAME  |  |                  |  |   |  | 14. MOTHER'S MAIDEN NAME  |  |  |                       |  |  |
| Eli Russler Hewitt   |  |                  |  |   |  | Sarah M. Cox  |  |  |                       |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                  |  |   |  | 16. SOCIAL SECURITY NO.   |  |  |                       |  |  |
| Yes WW II  |  |                  |  |   |  | 218-14-0614   |  |  |                       |  |  |
| 17. INFORMANT  |  |                  |  |   |  | Address   |  |  |                       |  |  |
| Mrs. Georgie W. Hewitt   |  |                  |  |   |  | 31 Pleasant Hill  |  |  |                       |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |                  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |                       |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |                  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |                       |  |  |
| IMMEDIATE CAUSE (a) Carcinomatosis   |  |                  |  |   |  | 1 yr. est.  |  |  |                       |  |  |
| 152.9 DUE TO   |  |                  |  |   |  | 1 1/2 yrs.  |  |  |                       |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  |                  |  |   |  | DUE TO  |  |  |                       |  |  |
| Adeno-carcinoma of small intestine   |  |                  |  |   |  |   |  |  |                       |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                  |  |   |  |   |  |  |                       |  |  |
| 19. WAS AUTOPSY PERFORMED?   |  |                  |  |   |  |   |  |  |                       |  |  |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |  |   |  |   |  |  |                       |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |                       |  |  |
| none   |  |                  |  |   |  |   |  |  |                       |  |  |
| 20c. TIME OF INJURY  |  |                  |  |   |  | 20d. INJURY OCCURRED  |  |  |                       |  |  |
| Hour   |  | s.m.             |  | p.m.  |  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>           |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |                       | 20f. (City or town)                          |  |
| none   |  | 19               |  |   |  |   |  |  |                       | (County) (State)                             |  |
| 21. I certify that (I) ( <del>HE</del> ) attended the deceased from 6-24-38 to 1-21-67, that (I) ( <del>HE</del> ) last saw the deceased alive on 1-20-67, and that death occurred at 8 a.m. from the causes and on the date stated above. |  |                  |  |   |  |   |  |  |                       |  |  |
| 22a. SIGNATURE   |  |                  |  |   |  | 22b. DATE SIGNED  |  |  |                       |  |  |
| D. D. Caples   |  |                  |  |   |  | 1-23-67   |  |  |                       |  |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                  |  |   |  | 22d. ADDRESS  |  |  |                       |  |  |
| D. D. Caples, M. D.  |  |                  |  |   |  | 6 Hanover Rd., Reisterstown, Md.  |  |  |                       |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                  |  |   |  | 23b. DATE THEREOF   |  | 23c. NAME OF CEMETERY OR CREMATORY                                     |                       | 23d. LOCATION (City, town or county) (State) |  |
| Burial   |  |                  |  |   |  | 1/24/67   |  | Evergreen Mem. Gardens   |                       | Finksburg, Maryland                          |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE   |  |                  |  |   |  | 25a. REC'D BY REGISTRAR   |  |  |                       |  |  |
| A. J. Schaub   |  |                  |  |   |  | DATE JAN 24 1967  |  |  |                       |  |  |
| ADDRESS  |  |                  |  |   |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                       |  |  |
| Owings Mills, Md.  |  |                  |  |   |  | f. Charles  |  |  |                       |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 00294

00292

|  |  |   |   |
|--|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO</b> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>  |  | c. LENGTH OF STAY IN 1b   |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <b>BRIDGEWAY Nursing Home.</b>   |  | e. STREET ADDRESS <b>1000 W. EDMONDSON AVE</b>  |   |
| 3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>N.</b> Last <b>Hill</b>   |  | 4. DATE OF DEATH Month <b>January</b> Day <b>15</b> Year <b>1967</b>  |   |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>W</b>  | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 7. DATE OF BIRTH <b>12-16-1886</b>                                |
| 8. AGE (In years last birthday) <b>80</b>  |  | 9. IF UNDER 1 YEAR: Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>  |   |
| 11. BIRTHPLACE (State or foreign country) <b>CHURCHTON, MD.</b>  |  | 12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>   |   |
| 13. FATHER'S NAME <b>JOHN WINDSOR</b>  |  | 14. MOTHER'S MAIDEN NAME <b>MARY HOWES</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b>   |  | 16. SOCIAL SECURITY NO <b>—</b>   |   |
| 17. INFORMANT <b>BERNARD FELD</b>  |  | Address <b>1002 ASTER BLVD. ROCKVILLE, MD. 20850</b>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b><br>DUE TO<br>(c) <b>—</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 wks.</b><br><b>9 yr.</b> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b><br>Hour a. m. <b>19</b> p. m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                              |
| 21. I certify that I attended the deceased from <b>6-10</b> , 1965, to <b>1-15</b> , 1967, that I last saw the deceased alive on <b>1-13</b> , 1967, and that death occurred at <b>6:30 A.M.</b> from the causes and on the date stated above.   |  |   |   |
| ACTUAL SIGNATURE <b>Wilmer K. Ballager</b>   |  | ADDRESS (Street, city or town, state) <b>6209 Frederick Ave</b> DATE SIGNED <b>1-15-67</b>  |   |
| PHYSICIAN'S NAME (Type) <b>Wilmer K. Ballager</b>  |  | <b>Baltimore, 21228 Md.</b>   |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)  | 22b. DATE THEREOF  | 22c. NAME OF CEMETERY OR CREMATORY  | 22d. LOCATION (City, town, or county) (State)                     |
| <b>Burial</b>  | <b>1-18-67</b>   | <b>CEDAR Bluff</b>  | <b>Annapolis Md.</b>  |
| 23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. V. L. L. L.</b>  |  | ADDRESS <b>Annapolis, Md.</b>   |   |
| 24a. REC'D BY REGISTRAR <b>18 1967</b>   |  | 24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |   |

20



FOR STATE  
HEALTH DEPT.

00293

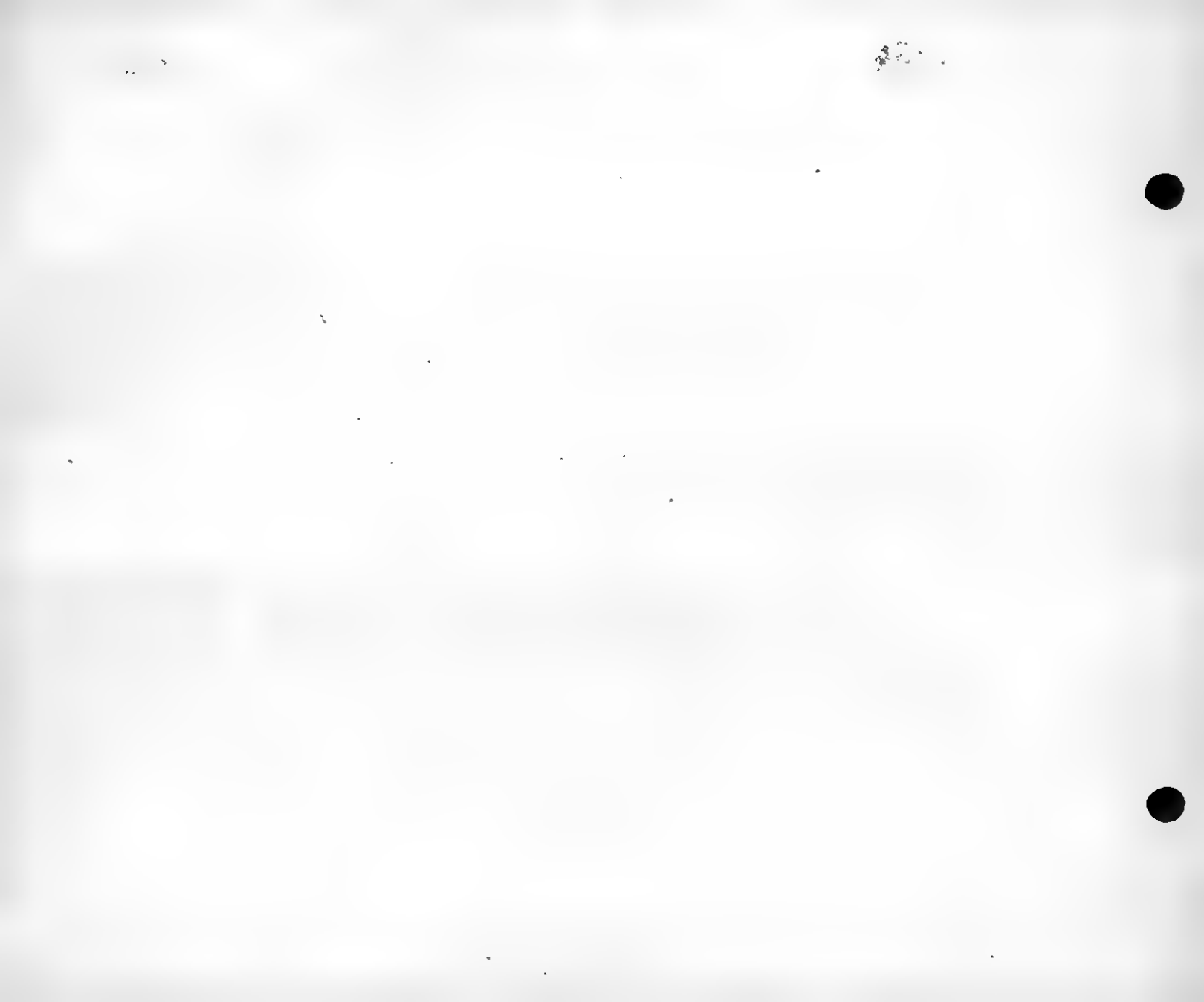
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00295

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in page 1 in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>o. COUNTY<br><b>BALTIMORE</b><br>MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>o STATE<br><b>MARYLAND</b><br>b COUNTY<br><b>BALTIMORE</b> |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>OELLA MD</b>  |   | c. LENGTH OF STAY in lb<br><b>79 yr</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>763 OELLA AVE</b>   |   | d. STREET ADDRESS<br><b>763 OELLA AVE</b>  |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>ERNEST (NMI) HOBSON</b>  |   | 4 DATE OF DEATH<br>Month Day Year<br><b>JAN 2 19 67</b>  |   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED<br><input checked="" type="checkbox"/> NEVER MARRIED<br><input type="checkbox"/> WIDOWED<br><input type="checkbox"/> DIVORCED            | 8 DATE OF BIRTH<br><b>FEB 11 1887</b>   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if ret red)<br><b>SPINNER</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>TEXTILE MFG</b>   | 9 AGE (In years last birthday)<br><b>79 yrs</b>                                       |
| 11 BIRTHPLACE (State or foreign country)<br><b>OELLA MD</b>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13 FATHER'S NAME<br><b>JOHN HOBSON</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>BARBARA REESE</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |   | 16. SOCIAL SECURITY NO<br><b>213096008</b>   |   |
| 17 INFORMANT<br><b>MRS JOHN HOBSON</b>   |   | Address<br><b>SAME ADDRESS</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>420.0 IMMEDIATE CAUSE (a) ARTERIO SCLEROTIC HEART DISEASE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) DUE TO<br>(c) DUE TO   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>John N. Snyder</b> MD   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>JOHN N. SNYDER</b>  |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |   |
|  |   | Address (Street, city, town, or county)<br><b>6348 FREDERICK</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1-5-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GOOD SHEPHERD</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>ELLKOTT CITY MD.</b>              |
| 24. FUNERAL DIRECTOR<br><b>F. RIGGIN BORTHON, ELLKOTT CITY MD</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 4 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                    |



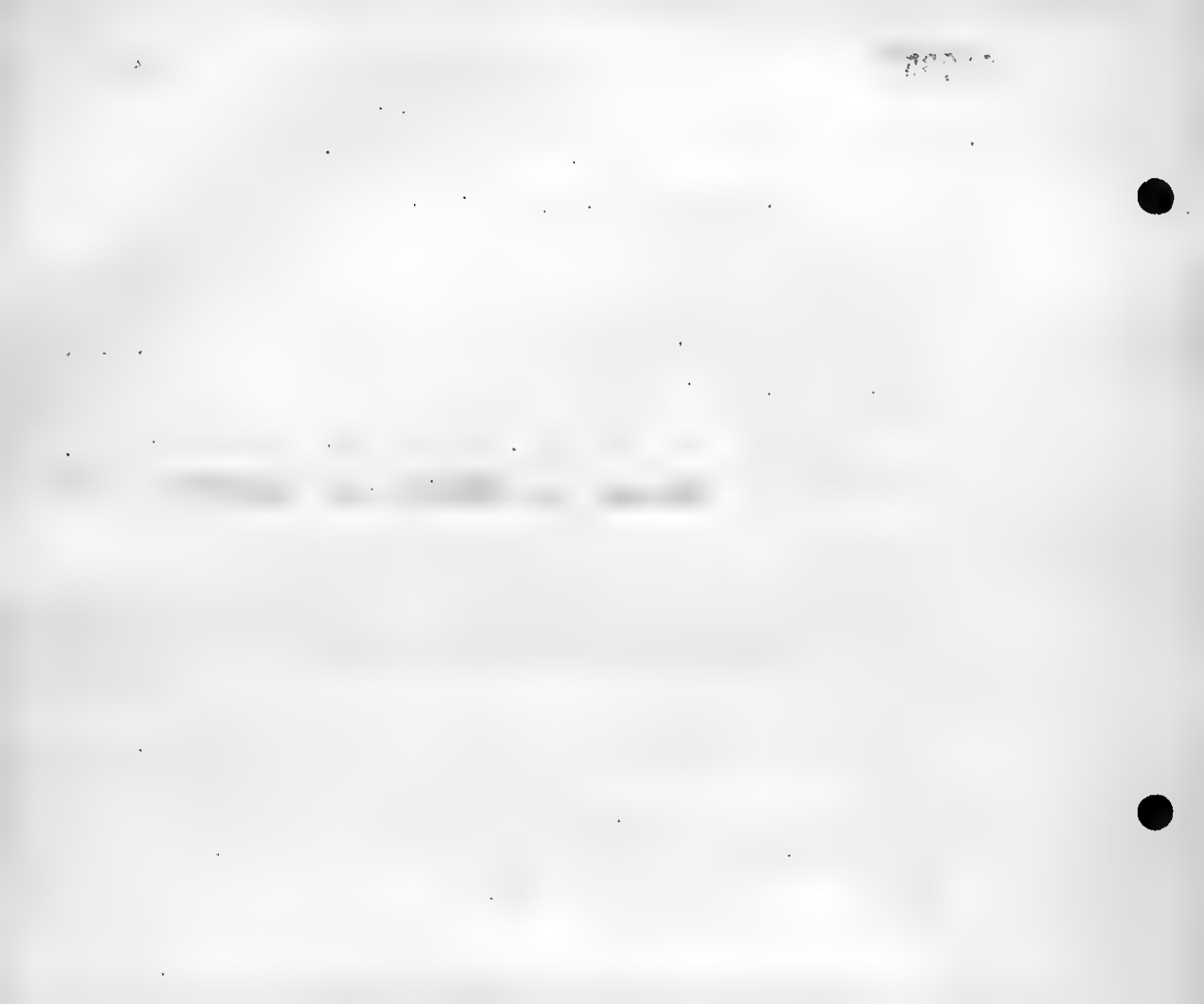


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                 |  |   |  |   |  |   |  |  |  |
|--|--|---------------------------------|--|---|--|---|--|---|--|--|--|
| 00294  |  |                                 |  |   |  | 00296   |  |   |  |  |  |
| 1. PLACE OF DEATH  |  |                                 |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)   |  |   |  |  |  |
| a. COUNTY <b>BALTIMORE</b> MARYLAND  |  |                                 |  |   |  | a. STATE <b>MARYLAND</b> b. COUNTY  |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  |                                 |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>                            |  |   |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>10 DAYS</b>  |  |                                 |  |   |  | d. STREET ADDRESS<br><b>814 E. 33<sup>rd</sup> STREET</b>   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>GREATER BALTIMORE MEDICAL CENTER</b>  |  |                                 |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                               |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)  |  |                                 |  |   |  | 4. DATE OF DEATH  |  |   |  |  |  |
| First Middle Last<br><b>JOHN E HOGBERG</b>   |  |                                 |  |   |  | Month Day Year<br><b>JAN 30 1967</b>  |  |   |  |  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>CAUC</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-16-89</b>  |  | 9. AGE (in years last birthday)<br><b>78</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |  |                                 |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Gen'l Contractor</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>SWEDEN</b>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                            |  |
| 13. FATHER'S NAME<br><b>JOHN P. HOGBERG</b>  |  |                                 |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |                                 |  | 16. SOCIAL SECURITY NO.<br><b>110-12-1517</b>   |  | 17. INFORMANT Address<br><b>Mr. John Hagenbucher 1505 Lakeside Ave</b>  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASES</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                 |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 YRS.</b>                          |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                 |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)                                    |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                                 |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-21</b> , 19 <b>67</b> , to <b>1-30</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-30</b> 19 <b>67</b> , and that death occurred at <b>3:15</b> A.M. from the causes and on the date stated above.   |  |                                 |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Evelyn L. Ramos</b> M.D.  |  |                                 |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1-30-67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>EVELYN L. RAMOS, M.D.</b>   |  |                                 |  |   |  | 22d. ADDRESS<br><b>GREATER BALTIMORE MEDICAL CENTER</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                 |  | 23b. DATE THEREOF<br><b>2/3/1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Immanuel Cemetery</b>  |  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Johnson &amp; Sons</b>   |  |                                 |  |   |  | ADDRESS<br><b>Balto. Md. north I-83A</b>  |  | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE<br><b>FEB 2 1967</b> <i>William J. Johnson</i> |  |  |  |



00295

## CERTIFICATE OF DEATH

00297

|   |                                     |   |   |
|---|-------------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>MARYLAND   |                                     | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>o. STATE<br><b>MARYLAND</b><br>b. COUNTY                            |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |                                     | c LENGTH OF STAY IN<br><b>74 DAYS</b><br><b>BALTIMORE</b>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                     | d STREET ADDRESS<br><b>1701 NORTH FULTON AVENUE</b>   |   |
| 3 NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>PHILIP W. HOLLAND</b>  |                                     | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 7 1967</b>   |   |
| 5 SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>NEGRO</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B DATE OF BIRTH<br><b>JULY 6, 1896</b>  |
| 9 AGE (In years last birthday) yrs<br><b>70</b>   |                                     | IF UNDER 1 YEAR<br>Months Days Hours Min<br><b>7 0 0 0</b>  |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>JANITOR</b>  |                                     | 10b KIND OF BUSINESS OR INDUSTRY<br><b>BAKERY</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>CATONSVILLE, MARYLAND</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |   |
| 13 FATHER'S NAME<br><b>EDWARD HOLLAND</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>CARRIE WOODLAND</b>  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>   |                                     | 16 SOCIAL SECURITY NO<br><b>214 26 94 88</b>  |   |
| 17 INFORMANT<br><b>VA HOSPITAL</b>  |                                     | 18. CLINICAL RECORDS<br><b>FORT HOWARD, MARYLAND</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>LEFT SUBPHRENIC ABSCESS</b><br>DUE TO (b) <b>GASTRIC ULCER WITH PERFORATION</b><br>DUE TO (c) <b>5401</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                     |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b><br><b>RECENT</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>CEREBRAL THROMBOSIS, OLD</b>   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |                                     | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                            |
| 20f. (City or town)   |                                     | (County) (State)  |   |
| 21. I certify that <b>17</b> (this hospital) attended the deceased from <b>OCT. 25</b> , 19 <b>66</b> , to <b>JAN 7</b> , 19 <b>67</b> , that <b>17</b> (we) last saw the deceased alive on <b>JAN 7</b> , 19 <b>67</b> , and that death occurred at <b>11:15 PM</b> , from causes and on the date stated above.                                |                                     |   |   |
| 22a. SIGNATURE<br><b>George Dudas</b>   |                                     | 22b. DATE SIGNED<br><b>1/9/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, M. D.</b>  |                                     | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1/12/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Marjorie P. Hayes</b>  |                                     | 25a. REC'D BY REGISTRAR<br><b>11 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                     | 25c. ADDRESS<br><b>HAYES FUNERAL HOME</b>   |   |
| 25d. ADDRESS<br><b>N. GILMORE ST. BALTIMORE, MD.</b>  |                                     |   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
5M 1/65

| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/>           Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND<br/> <b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b> </div>  |  |                                      |                          |   |   |   |   |  |   |
|--|--|--------------------------------------|--------------------------|---|---|---|---|--|---|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> <span style="float: right;">MARYLAND</span><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural</u><br>c. LENGTH OF STAY IN 1b <u>7 1/2 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4402 Vale Drive 36</u>  |  |                                      |                          |   | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - rural</u><br>d. STREET ADDRESS <u>4402 Vale Drive 36</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |  |   |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>RUSSELL CLYDE HOOPER TS</u><br>First Middle Last   |  |                                      |                          |   | <b>4. DATE OF DEATH</b> <u>Jan 18 1967</u><br>Month Day Year  |   |   |  |   |
| <b>5. SEX</b> <u>Male</u>  |  | <b>6. COLOR OR RACE</b> <u>White</u> |                          | <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | <b>8. DATE OF BIRTH</b> <u>Aug 23 1901</u><br>Yrs.  |   | <b>9. AGE</b> (In years last birthday) <u>65</u> yrs.<br>IF UNDER 1 YEAR: Months Days<br>IF UNDER 24 HRS: Hours Min. |   |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Engineer</u>   |  |                                      |                          | <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railroad</u>  |   | <b>11. BIRTHPLACE</b> (State or foreign country) <u>Harrisburg Pa.</u>                    |   | <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>   |   |
| <b>13. FATHER'S NAME</b> <u>George Austin Hooper</u>   |  |                                      |                          |   | <b>14. MOTHER'S MATEON NAME</b> <u>Caroline E Wise</u>  |   |   |  |   |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br>(If yes give war or dates of service)  |  |                                      |                          | <b>16. SOCIAL SECURITY NO.</b> <u>214-16-5543</u>   |   | <b>17. INFORMANT</b> <u>Helen A Hooper</u> <u>4422 Vale Drive</u><br>Address              |   |  |   |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Gun shot wound of head</u><br>976X DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Depression</u> |  |                                      |                          |   |   |   |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>inst</u> |
| <b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH?</b> <input type="checkbox"/>  |  |                                      |                          | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Gun shot wound of head</u>                               |   |   |   |  |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year <u>1-3 p.m. 1-18 1966</u>  |  |                                      |                          | <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>  |   | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u> |   | <b>20f. (City or town) (County) (State)</b> <u>Baltimore Baltimore Md.</u>   |   |
| <b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>       |  |                                      |                          |   |   |   |   |  |   |
| <b>ACTUAL SIGNATURE</b> <u>John C. Hyde</u><br><b>EXAMINER'S NAME (Type)</b> <u>JOHN C. HYDE</u>   |  |                                      |                          |   | <b>22. DATE SIGNED</b> <u>1-18-67</u><br><b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>  |   |   |  |   |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>   |  |                                      | <b>23b. DATE THEREOF</b> |   | <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Meadowridge Mem Park</u>   |   | <b>23d. LOCATION (City, town or county) (State)</b> <u>Howard Co. Md.</u> |  |   |
| <b>24. FUNERAL DIRECTOR</b> <u>Burgess General Home</u> <u>3639 Falk Rd Baltimore</u><br>ADDRESS   |  |                                      |                          |   | <b>25a. REC'D BY REGISTRAR</b>  |   | <b>25b. REGISTRAR'S SIGNATURE</b> <u>John Charles Judge</u>               |  |   |
| <b>DATE</b> <u>JAN 24 1967</u>   |  |                                      |                          |   |   |   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00297

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00299

|  |                                 |  |                                    |
|--|---------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |                                 | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>d. STREET ADDRESS<br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>BABY GIRL HORN</b>  |                                 | 4. DATE OF DEATH<br>Month Day Year<br><b>JAN 17 1967</b>   |                                    |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>Can.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>1-14-67</b> |
| 9. AGE (in years last birthday)<br>yrs. Months Days Hours Min.<br><b>3</b>   |                                 | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>10b. KIND OF BUSINESS OR INDUSTRY<br>11. BIRTHPLACE (County & State, or foreign country)<br><b>Balto. - Md.</b><br>12. CITIZEN OF WHAT COUNTRY?   |                                    |
| 13. FATHER'S NAME<br><b>Edward H Horn</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>Joy Ruth Oakes</b>  |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                 | 16. SOCIAL SECURITY NO.<br>17. INFORMANT<br><b>Admission Sheet.</b>  |                                    |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HYALINE MEMBRANE DISEASE</b><br>DUE TO <b>PREMATURE INFANT</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>30 DAYS</b><br><b>30 DAYS</b>   |                                    |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19  |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that (a) (this hospital) attended the deceased from <b>1-14</b> , 19 <b>67</b> , to <b>1-17</b> , 19 <b>67</b> , that (b) (we) last saw the deceased alive on <b>1-17</b> , 19 <b>67</b> , and that death occurred at <b>11:00</b> A.M. from the causes and on the date stated above.  |                                 |  |                                    |
| 22a. SIGNATURE<br><b>James T. Stinnell, III</b>  |                                 | 22b. DATE SIGNED<br><b>1-17-67</b>   |                                    |
| 22c. PHYSICIAN'S NAME (Type)   |                                 | 22d. ADDRESS   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                                 | 23b. DATE THEREOF<br><b>JAN 18, 1966</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREATER BALTO. MED. CTR.</b>  |                                 | 23d. LOCATION (City, town or county) (State)<br><b>6701 N. CHARLES BALTO. MD.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Barbara J. Peterson, M.D.</b>   |                                 | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 26 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |                                 |  |                                    |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |  |  |  |   |  |  |
|---|--|--|---|--|--|--|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |  |  |  |   |  |  |
| 00287   |  |  |   |  |  | 00289  |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>MARYLAND</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Maryland</u><br>c. LENGTH OF STAY IN 1b <u>18 mo's</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Nook Nursing Home - Rolling Road</u>  |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD (Birdsboro)</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u><br>d. STREET ADDRESS <u>4201 WESTVIEW RD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Mary</u> Middle <u>March</u> Last <u>Haw</u>   |  |  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>14</u> Year <u>67</u>   |  |  | 5. SEX <u>F</u>  |  |  | 6. COLOR OR RACE <u>W</u>   |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH<br><u>Oct 24 - 1884</u>  |  |  | 9. AGE (In years last birthday) <u>82</u> yrs  |  |  | IF UNDER 1 YEAR Months Days                                       |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |  |  | 11. BIRTHPLACE (County & State or foreign country) <u>Birdsboro, Penna</u>   |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>                       |  |  |
| 13. FATHER'S NAME <u>Isaac March</u>  |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME <u>Sara Livingston Birdsboro, Pa.</u>   |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)  |  |  |   |  |  | 16. SOCIAL SECURITY NO. 17. INFORMANT Address  |  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <u>Broncho - Pneumonia</u><br>DUE TO (b) <u>Advanced Arterio Sclerosis</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |  |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |   |  |  |  |  |  |   |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)   |  |  |   |  |  |  |  |  |   |  |  |
| 20c. TIME OF INJURY<br>Hour <u>19</u> e.m. p.m.   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  | 20f. (City or town) (County) (State)                              |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 13</u> 19 <u>67</u> to <u>Jan 13</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Jan 13</u> 19 <u>67</u> , and that death occurred at <u>1300</u> M, from the causes and on the date stated above.  |  |  |   |  |  |  |  |  |   |  |  |
| 22a. SIGNATURE <u>Wetherbee Fort</u> M.D.   |  |  |   |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22b. DATE SIGNED <u>1/14/67</u>                                   |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>  |  |  |   |  |  | 22d. ADDRESS <u>6 Dutton Ave. Catonsville 28</u>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |  | 23b. DATE THEREOF <u>1/17/67</u>  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHELS</u>  |  |  | 23d. LOCATION (City, town or county) (State) <u>BIRDSBORO, PA</u> |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN F. DENNY, INC.</u> ADDRESS <u>715 LIGHT ST. BALTO, MD</u>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>JAN 17 1967</u>  |  |  |   |  |  |

2313

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00298

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00300

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u>                    |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>BALTO</u>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Cockesville, Md.</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Greater BALTO Med Center</u>  |   | d. STREET ADDRESS<br><u>324 Warren Rd.</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Lee</u> Middle <u>Roy</u> Last <u>Howard</u>   |   | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>27</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>MALE</u>  | 6. COLOR OR RACE<br><u>COU</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6/29/1892</u>  |
| 9. AGE (in years last birthday)<br><u>74</u> yrs.  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired - Self emp. Carpenter</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTO, Md</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |   |
| 13. FATHER'S NAME<br><u>JosHA Howard</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Helen Magason</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>UNKNOWN</u>  |   | 16. SOCIAL SECURITY NO.<br><u>217-03-1690</u>   |   |
| 17. INFORMANT<br><u>Pt's history</u>   |   | Address   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>DUE TO (b) <u>metastatic carcinoma</u><br>DUE TO (c) <u>Adenocarcinoma of colon</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 13</u> , 19 <u>66</u> , to <u>Jan 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 27</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> AM, from the causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><u>Robert W. Smith</u>   |   | 22b. DATE SIGNED<br><u>1-27-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Robert W. Smith</u>   |   | 22d. ADDRESS<br><u>G.B.M.C.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Jan. 30, 1967</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Poplar Grove Cemetery</u>  | 23d. LOCATION (City, town or county) (State)<br><u>Cockesville, Md.</u>                           |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |   | 25a. REC'D BY REGISTRAR<br><u>J. Charles Judge</u>  |   |
| 25b. REGISTRAR'S SIGNATURE   |   | DATE<br><u>JAN 31 1967</u>  |   |

MEDICAL CERTIFICATION



00299

## CERTIFICATE OF DEATH

00301

|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore Co</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>md</u> b. COUNTY <u>---</u>                            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>FCW Sen</u>   |   | c. LENGTH OF STAY IN lb<br><u>14 yr + 7 mo</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>90 Aged Womens &amp; Aged Mens Home</u>   |   | d. STREET ADDRESS<br><u>3016 Belmont Ave</u>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>MARTHA M HOWARD</u>   |   | 4. DATE OF DEATH<br>Month Day Year<br><u>JAN 20 19 67</u>   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>6-3-1872</u>  |
| 9. AGE (In years last birthday)<br><u>94</u> yrs   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE, md</u>                          |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   | 13. FATHER'S NAME<br><u>Thomas Bowen</u>  |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Rebecca Disney</u>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>None</u>                                      |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>   |   | 17. INFORMANT<br><u>Charles Sherman</u> Address <u>615 Chestnut</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>422.1</u> IMMEDIATE CAUSE (a) <u>A</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>---</u><br>DUE TO<br>(c) <u>---</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 16</u> , 19 <u>52</u> , to <u>Jan. 20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 20</u> , 19 <u>67</u> , and that death occurred at <u>9:50</u> P.M. from causes and on the date stated above.        |   |   |  |
| 22a. SIGNATURE<br><u>NEWLAND E. DAY</u>  |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>NEWLAND E. DAY</u>  |   | 22d. ADDRESS  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1-23-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Jessops Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Cockeysville md.</u>                             |
| 24. FUNERAL DIRECTOR<br><u>Wm Cook-Bracks Towson Inc</u>   |   | 25a. REC'D BY REGISTRAR<br><u>1050 York Rd Towson, Md. 21204</u>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>J Charles Judge</u>   |   | DATE <u>JAN 25 1967</u>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When possible remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal) and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00300

CERTIFICATE OF DEATH

00302

|  |                                  |   |  |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution or Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>106 DAYS</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE - 21229</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                  | d. STREET ADDRESS<br><b>1038 COOKS LANE</b>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |
| 3. NAME OF DECEASED (Type or print)<br>First <b>PERCY</b> Middle <b>E.</b> Last <b>HOWARD</b>  |                                  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>5</b> Year <b>1966</b>  |  |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>FEBRUARY 11, 1890</b>   |
| 9. AGE (In years, months, days)<br><b>76 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  | 11. IF UNDER 24 HRS.<br>Months Days Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STOCK CLERK</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>KOPPERS COMPANY</b>   | 11. BIRTHPLACE (County & State or foreign country)<br><b>CALVERT COUNTY, MARYLAND</b>                        |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                  | 13. FATHER'S NAME<br><b>JOHN W. HOWARD</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ELLA E. SHERBERT</b>  |                                  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |  |
| 16. SOCIAL SECURITY NO<br><b>219 10 15 47</b>  |                                  | 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>332X CEREBRAL THROMBOSIS</b><br><b>XOXOX CORONARY THROMBOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>DUE TO</b><br>(c) <b>GENERALIZED ARTERIOSCLEROSIS</b> |                                  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>MONTHS</b><br><b>UNKNOWN</b>                         |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |
| 20f. (City or town) (County) (State)   |                                  | 21. I certify that (this hospital) attended the deceased from <b>9/21/66</b> , 19 to <b>1/5/67</b> , 19, that (I) (we) last saw the deceased alive on <b>1/5/67</b> , 19, and that death occurred at <b>8:40AM</b> from causes on and on the date stated above. |  |
| 22a. SIGNATURE<br><b>George Dudas, M.D.</b>  |                                  | 22b. DATE SIGNED<br><b>1/5/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, M. D.</b>   |                                  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>Jan. 9, 1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>WITZKE FUNERAL HOME</b>   |                                  | 25a. RECD BY REGISTRAR<br><b>JAN 6 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>EDMONDSON AVE. BALTIMORE, MD.</b>   |                                  | 25c. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISMF (5)  
SM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |   |  |                                  |  |   |                                  |
|---|--|--|---|---|--|----------------------------------|--|---|----------------------------------|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |   |  |                                  |  |   |                                  |
| 00301   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH      |   |   |  | 00304                            |  |   |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Baltimore County<br>MARYLAND  |  |  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br>Maryland<br>b. COUNTY<br>Baltimore                                    |                                  |  |   |                                  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>North Point Area  |  |  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Dundalk  |                                  |  |   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>7901 Baltimore St.  |  |  |   |   | d. STREET ADDRESS<br>7901 E. Baltimore St.   |                                  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br>Clara M. Hubbard  |  |  |   |   | 4. DATE OF DEATH<br>Month Day Year<br>Jan 21, 1967   |                                  |  |   |                                  |
| 5. SEX<br>Female  |  | 6. COLOR OR RACE<br>Caucasian                |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>May 23, 1907 |  | 9. AGE (In years last birthday)<br>59 yrs.  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>At Home |   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                              |   |                                  |
| 13. FATHER'S NAME<br>Henry Rohleder   |  |  |   |   | 14. MOTHER'S MAIDEN NAME<br>Lillian Bechers  |                                  |  |   |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  |  |   |   | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)   |                                  | 17. INFORMANT<br>Address<br>Melvin P. Hubbard 7901 Baltimore St. |   |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>H-S-C-V-Disease</u><br>Add'l <u>ADD'L</u> DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u> |  |  |   |   |  |                                  |  |   | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |  |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                  |  |   |                                  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)                             |   |                                  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                    |  |  |   |   |  |                                  |  |   |                                  |
| ACTUAL SIGNATURE <u>MB Davis</u>  |  |  |   |   | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> |                                  |  |   |                                  |
| EXAMINER'S NAME (Type) <u>Dr. Melvin B. Davis</u>   |  |  |   |   | DATE SIGNED <u>1/24/67</u>   |                                  |  |   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |  | 23b. DATE THEREOF<br>1/24/67  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Baltimore Cemetery   |                                  |  | 23d. LOCATION (City, town or county) (State)<br>Baltimore, Md.                                    |                                  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br>Dippel Bro's. Inc. 1800 E. Lombard St.   |  |  |   |   | 25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE<br>DATE <u>JAN 25 1967</u> <u>Charles Judge</u>   |                                  |  |   |                                  |

307

00302

CERTIFICATE OF DEATH

00305

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                  |   |  |   |  |  |  |
|---|----------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Harris</u> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWSON</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>8 years</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Savage</u> <u>12.3</u>                             |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>And Womans' Home</u>   |                                  |   |  | d. STREET ADDRESS   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mrs Mary Ann</u> Middle <u>Hunt</u> Last <u>Hunt</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>26</u> Year <u>1967</u>   |  |  |  |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Nov. 19, 1896</u> | 9. AGE (In years last birthday)<br><u>70</u> yrs  | 10. IF UNDER 1 YEAR<br>Months <u>6</u> Days <u>19</u> Hours <u>67</u> Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Savage, Md.</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |
| 13. FATHER'S NAME<br><u>Joseph Bounds</u>   |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>E. A. Sabers</u>   |  |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>216-10-1143</u>   |  | 17. INFORMANT<br><u>Daisy E. Hammett</u>  |  | Address<br><u>615 Chestnut Ave.</u>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ASCVD, Pulmonary Edema</u><br>DUE TO (b) <u>42.1</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>36 hrs</u> |                                  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 18, 1949</u> to <u>Jan. 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 26, 1967</u> , and that death occurred at <u>10:45 PM</u> , from causes and on the date stated above.                            |                                  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>Newland Edmund Day</u> M.D.  |                                  |   |  | 22b. DATE SIGNED<br><u>1-22-67</u>  |  | 22c. PHYSICIAN'S NAME (Type)<br><u>N. E. DAY</u> M.D.  |  |
| 22d. ADDRESS<br><u>4-E-33 1st Baltimore 21218 Md</u>  |                                  |   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                                  | 23b. DATE THEREOF<br><u>JAN. 30, 1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grace Methodist Church</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>SAVAGE MD.</u>                             |  |
| 24. FUNERAL DIRECTOR<br><u>Wm Cook-Brooks Inc. 1217 St. Paul St - Baltimore 2, MD.</u>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>JAN 30 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |



1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00308

CERTIFICATE OF DEATH

00308

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>Catonsville</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>107 Maiden Choice Lane</b>   |  | d. STREET ADDRESS<br><b>107 Maiden Choice Lane</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br><b>CHARLES D. IRWIN</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>17</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-6-1898</b>   |
| 9. AGE (In years last birthday)<br><b>68</b> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <b>6</b> Days <b>17</b> Hours <b>19</b> Mins <b>67</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Dock Hand</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>William Irwin</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Lewe</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>215-09-4561A</b>   |   |
| 17. INFORMANT<br><b>Mrs. Elizabeth O. Irwin, 107 Maiden Choice Lane</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary artery disease</b><br>DUE TO <b>Emphysema, chronic</b><br>DUE TO <b>6-7 years</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(c) |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Parenchymal lung fibrosis</b>   |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 14</b> , 19 <b>67</b> to <b>Jan 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Jan 17</b> , 19 <b>67</b> , and that death occurred at <b>2:15 P.M.</b> from causes and on the date stated above                                       |  |   |   |
| 22a. SIGNATURE<br><b>Robert B. Taylor MD</b>  |  | 22b. DATE SIGNED<br><b>1-18-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Robert W. Taylor</b>   |  | 22d. ADDRESS<br><b>111 Columbia Road, Ellicott City, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1-21-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue</b>   |  | 25a. RECD BY REGISTRAR<br><b>21229</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND [REDACTED] DEPT. OF HEALTH  
00304 001 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH 00307

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore Co.</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Reisterstown</b><br>c. LENGTH OF STAY IN b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1003 Dunholm Rd.</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MD</b><br>b. COUNTY <b>1003 Dunholm Rd.</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Rural Reisterstown</b><br>d. STREET ADDRESS <b>1003 Dunholm Rd.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print) <b>William V. Ischer</b><br>First Middle Last<br>4. DATE OF DEATH <b>January 1, 1967</b><br>Month Day Year   |  | 5. SEX <b>Male</b><br>6. COLOR OR RACE <b>White</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>  |  |
| 13. FATHER'S NAME <b>Phillip Ischer</b>  |  | 14. MOTHER'S MAIDEN NAME <b>Elizabeth Gerwig</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b><br>16. SOCIAL SECURITY NO. <b>215-32-9434</b>   |  | 17. INFORMANT <b>Margret C. Ischer 1003 Dunholm Rd.</b><br>Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Coronary Thrombosis - acute</b><br>DUE TO (b) <b>Arteriosclerosis - generalized</b><br>DUE TO (c) <b>Congestive Heart Failure - Chronic</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Minutes</b><br><b>Years</b><br><b>6 months</b>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>November 15, 1966</b> to <b>January 1, 1967</b> that (I) (we) last saw the deceased alive on <b>December 15, 1966</b> , and that death occurred at <b>3:20 PM</b> , from the causes and on the date stated above.   |  |   |  |
| 22a. SIGNATURE <b>Clarence E. McWilliams</b> M.D.  |  | 22b. DATE SIGNED <b>1-1-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>Clarence E. McWilliams M.D.</b>  |  | 22d. ADDRESS <b>11904 Reisterstown Rd. Reisterstown, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 23b. DATE THEREOF <b>1-5-67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>  |  | 23d. LOCATION (City, town or county) (State) <b>Pikesville Md.</b>  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Inc.</b>   |  | 25a. REC'D BY REGISTRAR <b>JAN 5 1967</b>   |  |
| ADDRESS <b>5305 Harford Rd.</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |

MARYLAND STATE DEPT.  
RECORDS.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |                               |   |                                    |  |  |   |  |   |  |
|---|-------------------------------|---|------------------------------------|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |                               |   |                                    |  |  |   |  |   |  |
| 00305   |                               |   |                                    |  | 00308  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY Baltimore  |                               |   |                                    |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE Maryland b. COUNTY Baltimore |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Sparrows Point  |                               |   | c. LENGTH OF STAY IN 1b<br>73 yrs. |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Sparrows Point 21219                       |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>814 E Street  |                               |   |                                    |  | d. STREET ADDRESS<br>814 E Street  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)  |                               | First   |                                    | Middle   |  | Last  |  | 4. DATE OF DEATH<br>Month Day Year  |  |
| LOLA  |                               | MCCLEARY  |                                    | ISENNOCK   |  | 5 January   |  | 1967  |  |
| 5. SEX<br>Female  | 6. COLOR OR RACE<br>Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |                                    | 8. DATE OF BIRTH<br>March 4, 1876  |  | 9. AGE (In years last birthday)<br>90 yrs.                              |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |                               |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>Maryland         |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Nelson McCleary  |                               |   |                                    |  | 14. MOTHER'S MAIDEN NAME<br>Martha Gill  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown)<br>No  |                               | 16. SOCIAL SECURITY NO.<br>(If yes give war or dates of service)<br>216/54/6937   |                                    | 17. INFORMANT<br>Bertha I. Adams ( as in 2 above)  |  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>430.0</u> <u>Chronic heart failure</u><br>DUE TO (b) <u>Generalized arteriosclerosis</u><br>DUE TO (c) <u>Chronic heart failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |                               |   |                                    |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 wk.<br>8 yrs  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               |   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br>19   |                               | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                       |  | 20f. (City or town) (County) (State)                                    |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from July, 1950, to Jan 5, 1967, that (I) (we) last saw the deceased alive on Jan 5, 1967, and that death occurred at M, from the causes and on the date stated above.   |                               |   |                                    |  |  |   |  |   |  |
| 22a. SIGNATURE<br>James T. Means  |                               |   |                                    | 22b. DATE SIGNED<br>1-6-67   |  | 22c. PHYSICIAN'S NAME (Type)<br>James T. Means                          |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |                               | 23b. DATE THEREOF<br>1/9/1967   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br>Clynmalira   |  | 23d. LOCATION (City, town or county) (State)<br>Monkton, Balto. Co., Md |  |   |  |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley   |                               |   |                                    | 25a. REC'D BY REGISTRAR<br>DATE JAN 9 1967   |  | 25b. REGISTRAR'S SIGNATURE<br>Charles Judge                             |  |   |  |

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Page 17 of 1000

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00306

## CERTIFICATE OF DEATH

00309

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |  | c. LENGTH OF STAY IN 1b<br><b>3 Months</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Towson Conv. Home</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Paul</b> Middle <b>James</b> Last <b>James</b>  |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>17</b> Year <b>1967</b>  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>Cauc.</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-10-1880</b><br>9. AGE (In years birth day)<br><b>86</b> yrs              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supv. Genesco</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Eng.</b>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Charles James</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Thiele / Anna Thiele</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>214 01 3415</b>  |   |
| 17. INFORMANT<br><b>Mrs. A.H. Gilpin, 220 Division Ave, Lutherville Md. 21093</b>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>4-1-1</b> IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b><br>DUE TO <b>Arteriosclerotic cardiovascular disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>(c) _____ |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b><br><b>15 yrs.</b>                                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>a.m.</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>December 1963</b> to <b>Jan. 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 16, 1967</b> , and that death occurred at <b>11 P.M.</b> from causes on and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><b>Lloyd E. Saylor</b>  |  | 22b. DATE SIGNED<br><b>1/19/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lloyd E. Saylor, M.D.</b>  |  | 22d. ADDRESS<br><b>3902 Greenmount Avenue</b>   |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Entombment</b>   | 23b. DATE THEREOF<br><b>1-21-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Baltimore, Md.</b>                  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 24 1967</b>  |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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2014



| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  |  |                                   |   |   |  |                             |   |  |   |
|--|--|-----------------------------------|---|---|--|-----------------------------|---|--|---|
| Item 14 Film G-1 2/1/67 rh   |  |                                   |   |   |  |                             |   |  |   |
| 00307  |  |                                   |   |   |  |                             |   |  |   |
| Reg. Dist. No. 00310   |  |                                   |   |   |  |                             |   |  |   |
| 1. PLACE OF DEATH<br>a. COUNTY<br>Baltimore  |  |                                   |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE<br>Md. |                             |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Catonsville  |  |                                   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Catonsville          |                             |   |  |   |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>726 Martin Drive  |  |                                   |   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                   |                             |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Edna Middle K. Last Jenkins   |  |                                   |   |   | 4. DATE OF DEATH<br>Month Jan. 24 Day 19 Year 67   |                             |   |  |   |
| 5. SEX<br>F  |  | 6. COLOR OR RACE<br>Wh            |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>10-2-91 |   | 9. AGE (In years lost birthday)<br>75 yrs. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY |   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |  |                             | 12. CITIZEN OF WHAT COUNTRY?<br>USA                 |  |   |
| 13. FATHER'S NAME<br>Late - --- Kroeger  |  |                                   |   |   | 14. MOTHER'S MAIDEN NAME<br>Unknown  |                             |   |  |   |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service))   |  |                                   |   |   | 16. SOCIAL SECURITY NO.  |                             |   |  |   |
|  |  |                                   |   |   | INFORMANT<br>Mr. Howard Jenkins<br>12 Somerset Rd.   |                             |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 332X Cerebrovascular Occlusion DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) After a fall from the Cerebrovascular Occlusion DUE TO<br>(c) |  |                                   |   |   |  |                             |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 wk.<br>6 yrs.   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |  |                                   |   |   |  |                             |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)              |                             |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. 19   |  |                                   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                                   |                             | 20f. (City or town) (County) (State)                |  |   |
| 21. I certify that I attended the deceased from 1956, to Jan 24, 1967, that I last saw the deceased alive on Jan 24, 1967, and that death occurred at 8:30 P.M., from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED<br>Nelson Mc Kay, M. D. 6014 Edmondson Ave. Jan 25, 1967           |  |                                   |   |   |  |                             |   |  |   |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  |                                   |   |   | 22b. DATE THEREOF<br>1-28-67   |                             | 22c. NAME OF CEMETERY OR CREMATORY<br>Woodlawn Cem. |  | 22d. LOCATION (City, town, or county) (State)<br>Baltimore, Md.                                   |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br>Witzke F. D. - 4101 Edmondson Ave.   |  |                                   |   |   | 24a. REC'D BY REGISTRAR<br>DATE JAN 27 1967  |                             | 24b. REGISTRAR'S SIGNATURE<br>Charles Judge         |  |   |



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |  |   |  |  |   |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |   |  |  |   |  |  |
| 00308   |  |  |   |  |  | 00311   |  |  |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br>c. LENGTH OF STAY IN 1b<br><b>For years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>   |  |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>city</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>city</b><br>d. STREET ADDRESS<br><b>1554 Lochwood Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Edward Baker Johnson</b>  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Jan. 28 1967</b>   |  |  | 5. SEX<br><b>Male</b>   |  |  | 6. COLOR OR RACE<br><b>white</b>                                      |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH<br><b>7-22-89</b>  |  |  | 9. AGE (In years last birthday)<br><b>77 yrs.</b>   |  |  | 10. UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.           |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Automobile mechanic</b>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |  |  |
| 13. FATHER'S NAME<br><b>Thomas Johnson</b>  |  |  |   |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Tensfield</b>   |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |  |  | 16. SOCIAL SECURITY NO.<br><b>212-28-5866</b>   |  |  | 17. INFORMANT<br>Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b><br><b>163X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |   |  |  |   |  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |  |  |   |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. 19   |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  | 20f. (City or town) (County) (State)                                  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-25, 1966</b> to <b>1-28, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-28, 1967</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.   |  |  |   |  |  |   |  |  |   |  |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>   |  |  |   |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |  | 22b. DATE SIGNED<br><b>1-28-67</b>                                    |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |  |  |   |  |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |  | 23b. DATE THEREOF<br><b>Feb 1, 1967</b>   |  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Park</b>   |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Taylor Ave. Md</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Austin E. Donovan - 3818 Roland Ave</b>  |  |  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>Jan 31 1967</b>   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                    |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

01840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

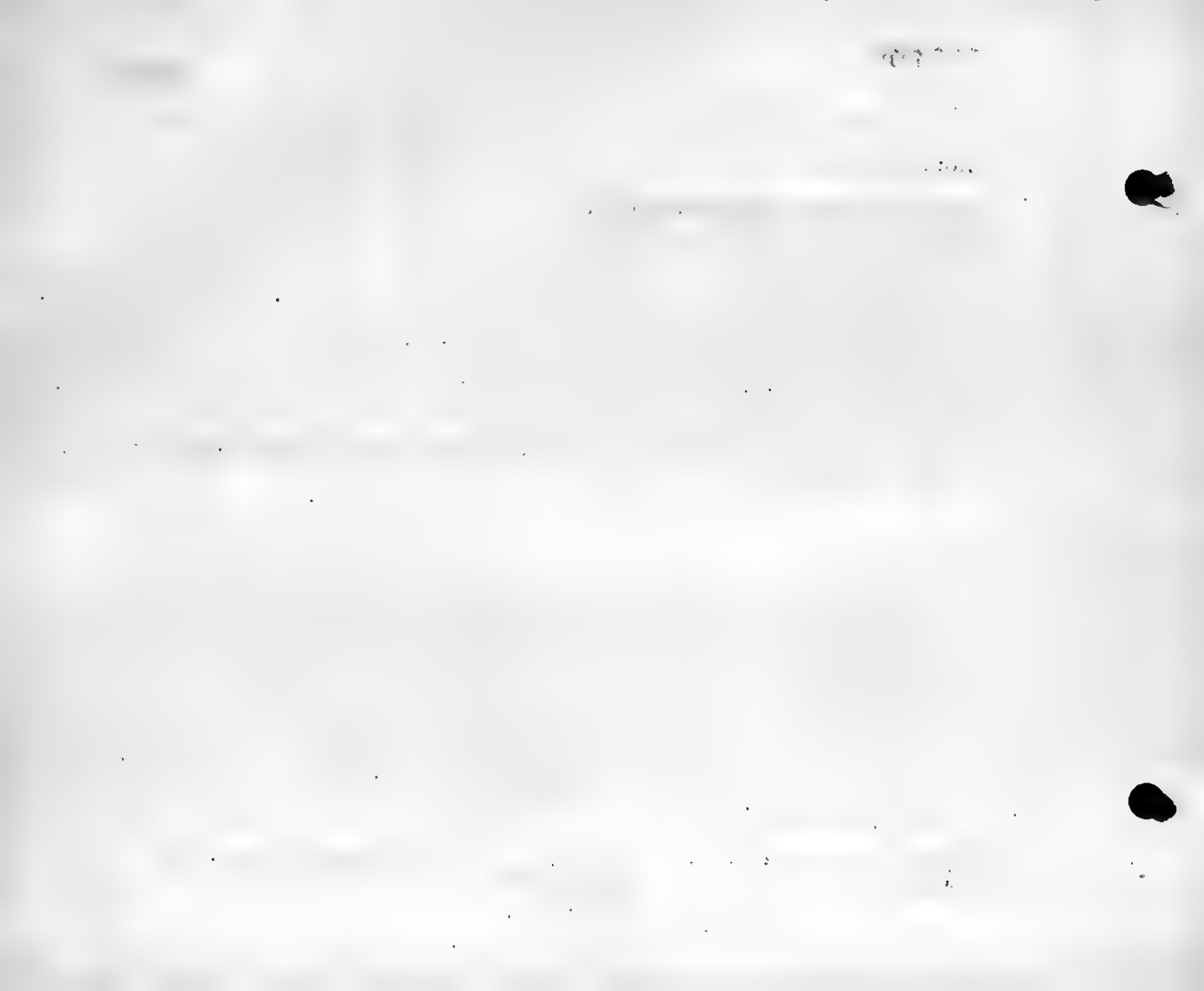
|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>White Hall, 21161</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>                                  |  | 2. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>1</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>White Hall, 21161</b><br>d. STREET ADDRESS<br><b>Bradenbaugh Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Todd</b><br>First Middle Last<br><b>JOHNSON</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 31, 1967</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>September 8, 1890</b><br>9. AGE (In years last birthday)<br><b>76 yrs</b><br>IF UNDER 1 YEAR<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b><br>12. CITIZEN OF WHAT COUNTRY?  |
| 13. FATHER'S NAME<br><b>Joseph Howard</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Johnson</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>217182506</b><br>17. INFORMANT<br><b>Eva B. Johnson White Hall</b><br>Address<br><b>21161</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Gastro-intestinal hemorrhage</b><br>DUE TO<br>575X<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b)<br>(c)  |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/16/</b> , 19 <b>67</b> , to <b>1/31/</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/31/</b> 19 <b>67</b> , and that death occurred at <b>8:45 M.</b> from causes and on the date stated above. |  |   |   |
| 22a. SIGNATURE<br><b>Melvin A. Ventum</b>   |  | 22b. DATE SIGNED<br><b>A.</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)  |  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>2-4-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Grove</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Shore Baltimore Md</b>  |
| 24. FUNERAL DIRECTOR<br><b>GEORGE W TITTLE</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 9 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>George W. Tittle</b>   |

14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |   |   |   |   |   |   |   |  |
|--|--|---|---|---|---|---|---|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |   |   |   |   |   |   |  |
| 00309  |  |   |   |   | 00312   |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br>c. LENGTH OF STAY IN 1b<br><b>14 mo 23 d</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>   |  |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>2806 2nd Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Era Virginia Kates</b>   |  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>1 14 1967</b>  |   | 5. SEX<br><b>F</b>  |   |   |   |  |
| 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>11-29-88</b>                 |   | 9. AGE (in years last birthday)<br><b>78</b> yrs. |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>AT Home</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                   |   |  |
| 13. FATHER'S NAME<br><b>Lawrence Mallonee</b>  |  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Mc Gee</b> |   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>215-54-0760</b>   |   | 17. INFORMANT<br><b>Records, Mount Wilson State Hospital</b><br>Address   |   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hiatal hernia, Exfoliative Psoriasis.</b><br>19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |   |   |   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)              |   |   |   |   |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                            |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10-22-1965</b> to <b>1-14-1967</b> , that (I) (we) last saw the deceased alive on <b>1-14-1967</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above.   |  |   |   |   |   |   |   |   |  |
| 22a. SIGNATURE<br><b>M. Newcomer</b>   |  |   |   |   | 22b. DATE SIGNED<br><b>1-14-67</b>  |   |   |   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M. Newcomer, M.D., Supt.</b>  |  |   |   |   | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>   |   |   |   |  |
| 23a. <del>BURIAL</del> CREMATION, <del>Funeral Home (Specify)</del>  |  |   | 23b. DATE THEREOF<br><b>1-17-67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENMOUNT</b>   |   | 23d. LOCATION (City, town or county) (State)<br><b>BALTO MD</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Chas. F. Evanson</b>  |  |   |   |   | 25a. REC'D BY REGISTRAR<br><b>8802 Hartom Rd</b>  |   |   |   |  |
|  |  |   |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>JAN 17 1967</b>  |   |   |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

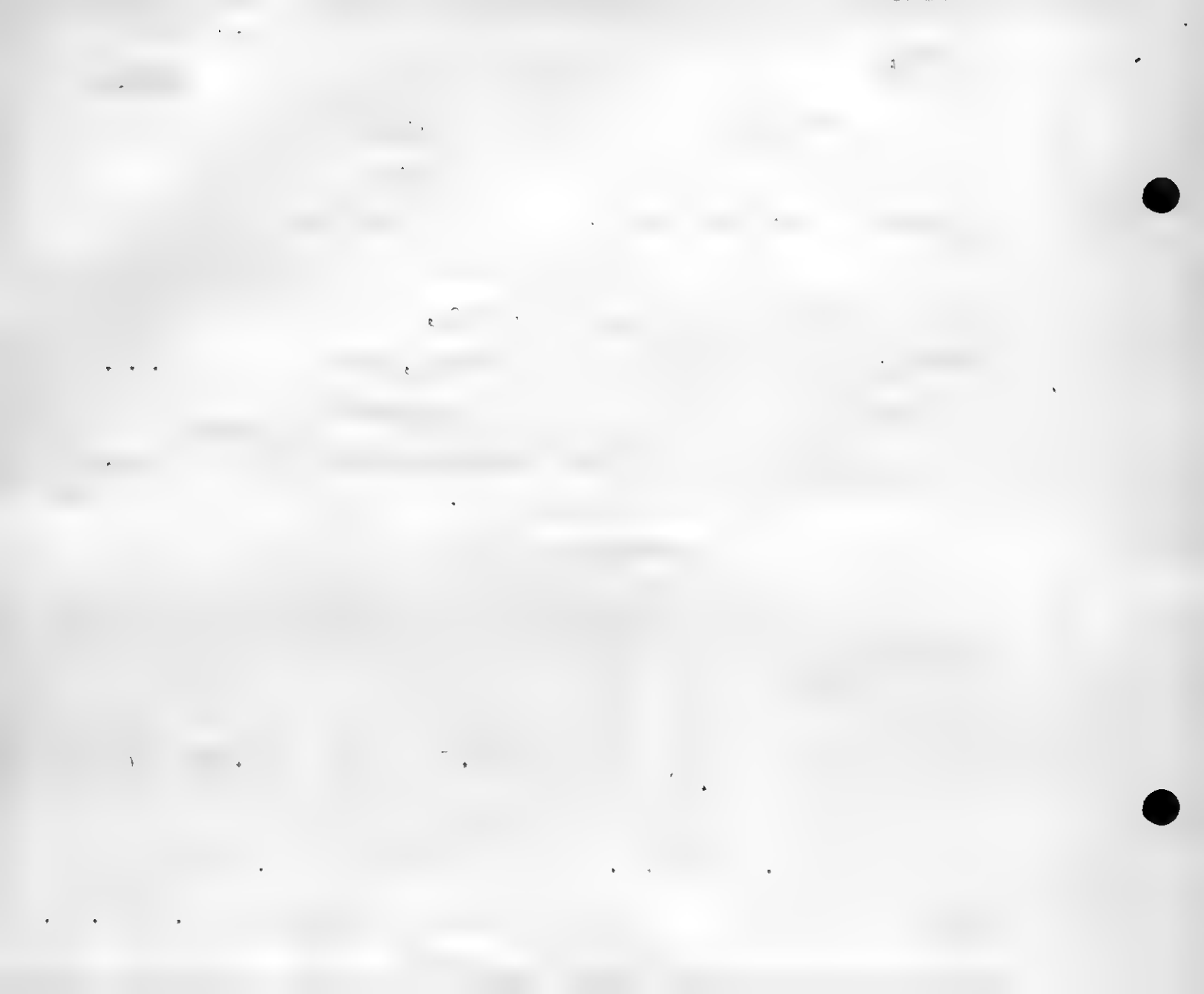
00310

## CERTIFICATE OF DEATH

00313

|   |                               |  |  |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>   |  |
| c. LENGTH OF STAY IN 1b <b>6 DAYS</b>   |                               | d. STREET ADDRESS <b>8621 WOODSPRING ROAD</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>  |                               | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>DR. ALBERT HERBERT KATZ</b>   |                               | 4. DATE OF DEATH <b>JANUARY 24 19 67</b>   |  |
| 5. SEX <b>MALE</b>  | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>JUNE 23, 1914</b>                |
| 9. AGE (In years last birthday) <b>52</b> yrs   |                               | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b>   | 11. IF UNDER 24 HRS.<br>Hours <b>0</b> Min. <b>0</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PHYSICIAN</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICINE</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>DUBOIS, PENNA</b>  |                               | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13. FATHER'S NAME <b>MARCUS KATZ</b>  |                               | 14. MOTHER'S MAIDEN NAME <b>JENNY SHULMAN</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW II</b>  |                               | 16. SOCIAL SECURITY NO. <b>212 32 84 81</b>  |  |
| 17. INFORMANT <b>VA HOSPITAL CLINICAL RECORDS</b>   |                               | 18. FORT HOWARD, MARYLAND  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL</b><br>DUE TO <b>75001</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ENDOCARDITIS, ACUTE</b><br>(c) |                               |  | INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE SCLEROSIS</b>   |                               |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                               | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                               | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                               | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |  |
| 20f. (City or town) (County) (State)  |                               | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JAN. 18</b> , 19 <b>67</b> , to <b>JAN. 24</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JAN. 24</b> , 19 <b>67</b> , and that death occurred at <b>925 PM</b> , from causes and on the date stated above. |  |
| 22a. SIGNATURE <i>Peter V. Juvan</i>  |                               | 22b. DATE SIGNED <b>1/25/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>PETER V. JUVAN, M. D.</b>   |                               | 22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                               | 23b. DATE THEREOF <b>1/26/67</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>BETH TFILOH CEMETERY</b>  |                               | 23d. LOCATION (City or Town) (County) (State) <b>WINDSOR MILL RD. BALTO. MD.</b>   |  |
| 24. FUNERAL DIRECTOR <b>SOL LEVENSON &amp; BROTHERS</b>   |                               | 25a. REC'D BY REGISTRAR <b>JAN 31 1967</b>   |  |
| <b>BALTIMORE, MARYLAND</b>  |                               | 25b. REGISTRAR'S SIGNATURE <i>James Judge</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00311

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00314

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BAL TO.</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BAL TO.</u>   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Essex</u>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Essex</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>1 FAIRWAY RD.</u>  |   | d. STREET ADDRESS<br><u>1 FAIRWAY</u>  |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>PAUL K. Kepner</u>   |   | 4 DATE OF DEATH<br>Month <u>JAN</u> Day <u>28</u> Year <u>1967</u>   |   |
| 5 SEX<br><u>MALE</u>  | 6. CO. OR OR RACE<br><u>W</u>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><u>MAY 18-1900</u> 66 yrs                              |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MACHINIST</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>GLEN-MARTIN</u>  |   |
| 11 BIRTHPLACE (State or foreign country)<br><u>PA.</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13 FATHER'S NAME<br><u>Levi Kepner</u>  |   | 14 MOTHER'S MAIDEN NAME<br><u>HOFFINE</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16 SOC. A. SECURITY NO.<br><u>173-03-0857A</u>   |   |
| 17 INFORMANT<br><u>Wife</u>   |   | Address<br><u>SAME</u>   |   |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br><u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u><br>DUE TO (b) <u>A-S-C-V Disease</u><br>DUE TO (c) <u>—</u>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>—</u>   |   |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)<br><u>None</u>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><u>M.B. Davis</u>   |   | 22. DATE SIGNED<br><u>1/28/67</u>  |   |
| EXAMINER'S NAME (Type) <u>M. B. Davis</u>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>1/31/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Cape Lawn Cem</u>   | 23d. LOCATED ON (City or Town) (County) (State)<br><u>Balto</u> <u>MD</u> |
| 24. FUNERAL DIRECTOR<br><u>J. G. Connelly Sons - 300 MACE (21)</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 31 1967</u>   |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or entombment, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

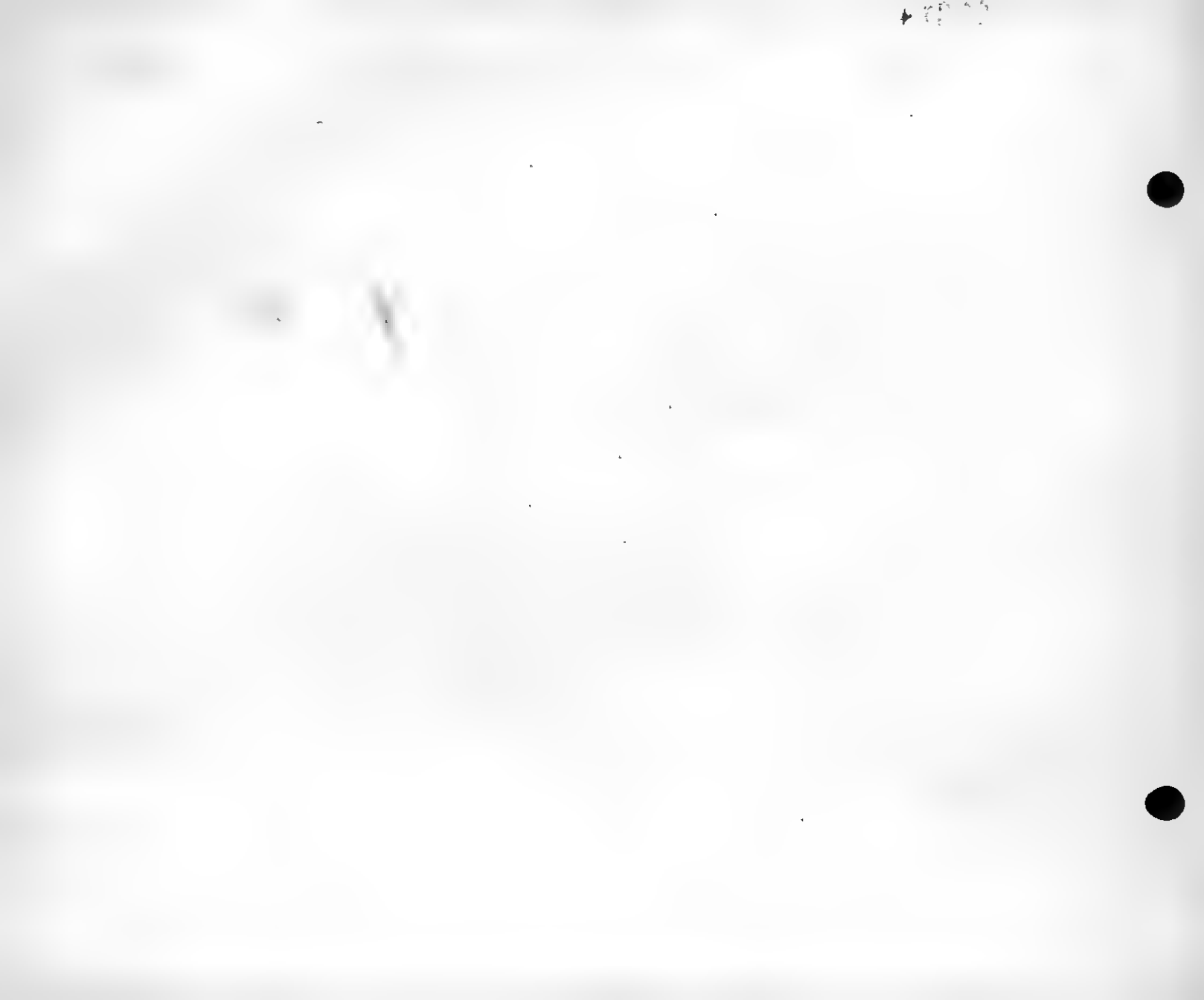
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00312

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00315

|  |                           |  |  |
|--|---------------------------|--|--|
| 1. PLACE OF DEATH<br>a COUNTY <u>BALTIMORE</u> MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a STATE <u>MARYLAND</u> b COUNTY <u>P. GEORGE</u>               |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u>  |                           | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>COLLEGE PARK</u>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SPRING BROOK STATE HOSP.</u>   |                           | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>AURELIA</u> Middle <u>KINARD</u> Last <u>KINARD</u>  |                           | 4. DATE OF DEATH<br>Month <u>JAN.</u> Day <u>9</u> Year <u>1967</u>  |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>N</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2/22/96</u>                                      |
| 9. AGE (in years, months, days)<br><u>70</u> yrs   |                           | 10. F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11. BIRTHPLACE (If foreign, give country)<br><u>S. C.</u>  |                           | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>EDMUND ABRAMS</u>  |                           | 14. MOTHER'S MAIDEN NAME   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)   |                           | 16. SOCIAL SECURITY NO<br><u>251-07-9995</u>   |  |
| 17. INFORMANT<br><u>AKART</u>  |                           | Address  |  |
| 18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC VASCULAR DISEASE</u><br>DUE TO <u>URINARY TRACT INFECTION</u><br>DUE TO <u>DECUBITUS ULCER INFECTED</u><br>DUE TO <u>TRACTURE OF LEFT FEMUR</u>  |                           |  | INTERVA. BETWEEN ONSET AND DEATH<br><u>2 MONTH</u>                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>CHRONIC BRAIN SYNDROME, 20% SENILITY</u>  |                           |  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>  |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><u>FELL from a chair 10/5/65</u>                           |  |
| 20c. TIME OF INJURY Month Day Year<br><u>10/5/65</u> hour <u>6</u> m. <u>10</u> p.m.   |                           | 20d. INJURY OCCURRED<br>Where <input type="checkbox"/> at work <input checked="" type="checkbox"/> Not While at work                                     |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Spring Grove Hosp.</u>  |                           | 20f. (City or town) (County) (State)<br><u>Catonsville Md.</u>   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                           |  |  |
| ACTUAL SIGNATURE<br><u>P. K. K...</u>  |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><u>E. KASARI's, M.D.</u>   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 22. DATE SIGNED<br><u>1/9/67</u>   |                           | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| Address (Street, city, town, or county)  |                           |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>1-15-67</u>  | 23b. DATE THEREOF         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Helborn Baptist em.</u>   | 23d. LOCATION (City or town) (County) (State)<br><u>Clinton S.C.</u> |
| 24. FUNERAL DIRECTOR<br><u>Rev. A. Nelson</u>  |                           | 25a. REC'D BY REGISTRAR<br><u>1348 n. Calhoun st</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                           | DATE <u>JAN 13 1967</u>  |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any body is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AISME  
SM 1/63

00313

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00316

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <b>Maryland</b> COUNTY <b>Baltimore</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Marsh</b>                                       |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hamilton Place Farm</b>  |  |  |  | e. STREET ADDRESS <b>Hamilton Place Farm</b>  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>DORA</b> First <b>YATES</b> Middle <b>King</b> Last   |  | 4. DATE OF DEATH <b>Jan 6 1967</b> Month <b>Jan</b> Day <b>6</b> Year <b>1967</b>  |  | 5. SEX <b>female</b>  |  | 6. COLOR OR RACE <b>white</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>8/3/80</b>   |  | 9. AGE (In years last birthday) <b>86</b> yrs.  |  | IF UNDER 1 YEAR Months Days   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Virginia</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                                      |  |
| 13. FATHER'S NAME <b>Andrew Jackson YATES</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME <b>Mertice Browning</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  | 16. SOCIAL SECURITY NO. <b>577-36-6773</b>   |  | 17. INFORMANT <b>H. M. Grayson (niece) some</b> Address   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiac Vascular Disease</b><br>DUE TO (b) <b>- Aging &amp; terminal dehydration</b><br>DUE TO (c) <b>Cachexia</b>   |  |  |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH <b>none</b> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |   |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |   |  |   |  |
| ACTUAL SIGNATURE <b>John C. Hyle</b>   |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
| EXAMINER'S NAME (Type) <b>JOHN C. Hyle</b>   |  |  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |   |  |
|  |  |  |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>1-6-67</b>   |  |   |  |
|  |  |  |  | Address (Street, city, town, or county)   |  |   |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>   |  | 22b. DATE THEREOF <b>1/6/67</b>  |  | 22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>   |  | 22d. LOCATION (City, town, or county) (State) <b>Prince Georges County, Md.</b> |  |
| 23. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> ADDRESS <b>Washington, D.C.</b>   |  |  |  | 24a. REC'D BY REGISTRAR <b>JAN 9 1967</b> DATE  |  |   |  |
|  |  |  |  | 24b. REGISTRAR'S SIGNATURE <b>Charles J. [illegible]</b>  |  |   |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                   |  |   |   |                              |                              |                                 |  |
|--|--|-----------------------------------|--|---|---|------------------------------|------------------------------|---------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                   |  |   |   |                              |                              |                                 |  |
| 00314  |  |                                   |  |   | 00317   |                              |                              |                                 |  |
| 1. PLACE OF DEATH  |  |                                   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |                              |                              |                                 |  |
| a. COUNTY  |  | Baltimore                         |  |   | a. STATE  |                              | Maryland                     |                                 |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)   |  | Rogers Forge Community            |  |   | b. COUNTY   |                              | Baltimore                    |                                 |  |
| c. LENGTH OF STAY IN 1b  |  |                                   |  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)      |                              | Rogers Forge Community 21212 |                                 |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)   |  |                                   |  |   | d. STREET ADDRESS   |                              |                              |                                 |  |
| 202 Overbrook Road   |  |                                   |  |   | 202 Overbrook Road  |                              |                              |                                 |  |
| 3. NAME OF DECEASED (Type or print)  |  |                                   |  |   | 4. DATE OF DEATH  |                              |                              |                                 |  |
| First  |  | Middle                            |  | Last  |   | Month                        |                              | Day Year                        |  |
| Mabel J.   |  | Kinsey                            |  |   |   | January 14,                  |                              | 19 67                           |  |
| 5. SEX   |  | 6. COLOR OR RACE                  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    |   | 8. DATE OF BIRTH             |                              | 9. AGE (in years last birthday) |  |
| Female   |  | White                             |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | December 10, 1885            |                              | 87 yrs.                         |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10b. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (County & State, or foreign country)                           |   | 12. CITIZEN OF WHAT COUNTRY? |                              |                                 |  |
| Housewife  |  | Own Home                          |  | Maryland  |   | USA                          |                              |                                 |  |
| 13. FATHER'S NAME  |  |                                   |  | 14. MOTHER'S MAIDEN NAME  |   |                              |                              |                                 |  |
| Singleton Howes  |  |                                   |  | Maria Howes   |   |                              |                              |                                 |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.           |  | 17. INFORMANT   |   | Address                      |                              |                                 |  |
| No   |  | None                              |  | Family records  |   |                              |                              |                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))   |  |                                   |  |   |   |                              |                              |                                 |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)   |  |                                   |  |   |   |                              |                              |                                 |  |
| Arteriosclerotic Heart Disease   |  |                                   |  |   |   |                              |                              |                                 |  |
| DUE TO   |  |                                   |  |   |   |                              |                              |                                 |  |
| Generalized Arteriosclerosis   |  |                                   |  |   |   |                              |                              |                                 |  |
| DUE TO   |  |                                   |  |   |   |                              |                              |                                 |  |
| Interval between onset and death: 2 years  |  |                                   |  |   |   |                              |                              |                                 |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                   |  |   |   |                              |                              |                                 |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20c. TIME OF INJURY Month, Day, Year   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20d. INJURY OCCURRED   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 20f. (City or town) (County) (State)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 21. I certify that (I) (the hospital) attended the deceased from Jan 1, 1967, to Jan 14, 1967, that (I) (we) last saw the deceased alive on Jan 13, 1967, and that death occurred at 4:20 P.M. from the causes and on the date stated above. |  |                                   |  |   |   |                              |                              |                                 |  |
| 22a. SIGNATURE   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22b. DATE SIGNED   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22c. PHYSICIAN'S NAME (Type)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22d. ADDRESS   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  |                                   |  |   |   |                              |                              |                                 |  |
| 22f. ADDRESS   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22g. DATE  |  |                                   |  |   |   |                              |                              |                                 |  |
| 22h. REGISTRAR'S SIGNATURE   |  |                                   |  |   |   |                              |                              |                                 |  |
| 22i. DATE  |  |                                   |  |   |   |                              |                              |                                 |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |  |                                   |  |   |   |                              |                              |                                 |  |
| 23b. DATE THEREOF  |  |                                   |  |   |   |                              |                              |                                 |  |
| 23c. NAME OF CEMETERY OR CREMATORY   |  |                                   |  |   |   |                              |                              |                                 |  |
| 23d. LOCATION (City, town or county) (State)   |  |                                   |  |   |   |                              |                              |                                 |  |
| 24. FUNERAL DIRECTOR   |  |                                   |  |   |   |                              |                              |                                 |  |
| 25a. REC'D BY REGISTRAR  |  |                                   |  |   |   |                              |                              |                                 |  |
| 25b. REGISTRAR'S SIGNATURE   |  |                                   |  |   |   |                              |                              |                                 |  |
| 25c. DATE  |  |                                   |  |   |   |                              |                              |                                 |  |

MEDICAL CERTIFICATION

LARRYSTON L. KEOWN M.D.

Jan. 17, 1967 Meadowridge Memorial Cem. Elbridge, Maryland

John Burns' Sons, Towson, Maryland

JAN 19 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

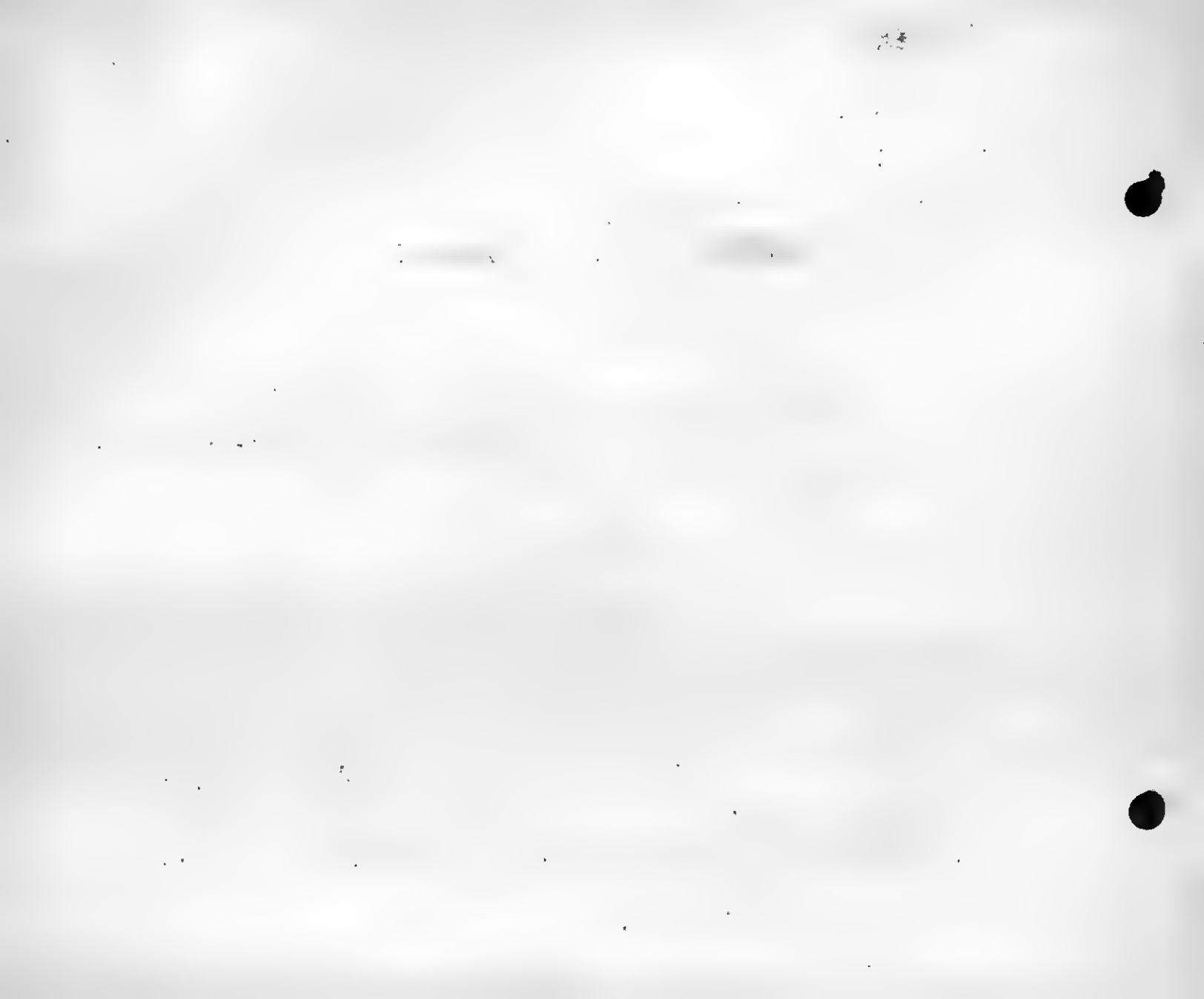
**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

00315

00318

|   |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|--|--|---|--|
| <b>1. PLACE OF DEATH</b><br><b>a. COUNTY</b><br><b>Baltimore County</b> <span style="float: right;">MARYLAND</span><br><b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br><b>c. LENGTH OF STAY IN 1b</b><br><b>2 mo 11 days</b><br><b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br><b>a. STATE</b> <b>Maryland</b> <b>b. COUNTY</b> <b>Cecil Co.</b><br><b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town)<br><b>North East</b><br><b>d. STREET ADDRESS</b><br><b>e. IS RESIDENCE ON A FARM?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><b>CURTIS</b> <b>DAVIS</b> <b>KIRK</b>  |  | <b>4. DATE OF DEATH</b><br>Month <b>1</b> Day <b>14</b> Year <b>1967</b> |  | <b>5. SEX</b><br><b>M</b>   |  | <b>6. COLOR OR RACE</b><br><b>W</b>   |  | <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><b>8-13-04</b>                                       |  | <b>9. AGE</b> (In years last birthday)<br><b>62 yrs.</b> |  | <b>IF UNDER 1 YEAR</b> Months <b>1</b> Days <b>14</b> Hours <b>19</b> Min. <b>67</b><br><b>IF UNDER 24 HRS.</b> |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Railroad engineer</b>  |  |  |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>INDUSTRY</b>   |  |   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><b>Maryland</b>   |  |   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A</b>      |  |   |  |
| <b>13. FATHER'S NAME</b><br><b>Cecil Kirk</b>   |  |  |  |   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>ALICE DAVIS</b>                         |  |   |  |   |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |  |  |  | <b>16. SOCIAL SECURITY NO.</b><br><b>160-16-2669</b>  |  |   |  | <b>17. INFORMANT</b> Address<br><b>Records, Mt. Wilson State Hospital</b>   |  |   |  |  |  |   |  |
| <b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]<br><b>PART I. DEATH WAS CAUSED BY:</b><br><b>IMMEDIATE CAUSE (a)</b> <b>Cor Pulmonale</b><br><b>5211</b> <b>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.</b><br><b>(b) Pulmonary Emphysema</b><br><b>(c)</b><br><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> |  |  |  |   |  |   |  |   |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>12 mo'</b> |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |   |  |   |  |  |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) |  | <b>20f. (City or town)</b> (County) (State)   |  |   |  |  |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>11-3-1966</b> , <b>to</b> <b>1-14-1967</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>1-14-1967</b> , <b>and that death occurred at</b> <b>10 A.M.</b> , <b>from the causes and on the date stated above.</b>   |  |  |  |   |  |   |  |   |  |   |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><b>W. Newcomer</b>   |  |  |  |   |  |   |  |   |  |   |  | <b>22b. DATE SIGNED</b><br><b>1-14-67</b>                |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><b>Wm. Newcomer, M.D., Superintendent</b>  |  |  |  |   |  | <b>22d. ADDRESS</b><br><b>Mount Wilson, Maryland</b>                          |  |   |  |   |  |  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>   |  |  |  | <b>23b. DATE THEREOF</b><br><b>1/17/67</b>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>WEST NOTTINGHAM</b>           |  |   |  | <b>23d. LOCATION (City, town or county)</b> (State)<br><b>COLORA CECIL, MD.</b> |  |  |  |   |  |
| <b>24. FUNERAL DIRECTOR</b> <b>RALPH M. REED</b> ADDRESS<br><b>Ralph M. Reed RISING SON, MD</b>   |  |  |  |   |  | <b>25a. REC'D BY REGISTRAR</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>   |  |   |  |  |  |   |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B-1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00316

CERTIFICATE OF DEATH

00319

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Maryland</u> <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>548 Sudbrook Lane</u> |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u><br>d. STREET ADDRESS <u>548 Sudbrook Lane</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Edward</u> <u>Klasman</u><br>First Middle Last<br>4. DATE OF DEATH <u>January 9</u> 19 <u>67</u><br>Month Day Year   |  |  |  | 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 21, 1910</u> 9. AGE (in years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.                                      |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CPA</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                            |  |  |  | 13. FATHER'S NAME <u>Max Klasman</u> 14. MOTHER'S MAIDEN NAME <u>Bessie</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>213-36-2040</u> 17. INFORMANT <u>Edna Klasman</u> Address <u>548 Sudbrook Lane</u>   |  |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>420.1 Cardio Respiratory Failure</u><br>DUE TO (b) <u>Ac Myocardial Infarction</u><br>DUE TO (c) <u>(massive)</u><br>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 <input type="checkbox"/> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 30</u> , 19 <u>63</u> to <u>Jan 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 9</u> , 19 <u>67</u> , and that death occurred at <u>12:05</u> M, from the causes and on the date stated above.       |  |  |  |  |  |  |  |
| 22a. SIGNATURE <u>Richard Appleseed</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/5/67</u>   |  |  |  | 22c. PHYSICIAN'S NAME (Type) <u>Richard Appleseed</u> 22d. ADDRESS <u>5501 Park Heights Dr</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan 10/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Rest. - Baltimore, Md</u> 23d. LOCATION (City, town or county) (State)  |  |  |  | 24. FUNERAL DIRECTOR <u>Sal Lennon</u> ADDRESS <u>912 N - 6000 Reisterstown</u> 25a. REC'D BY REGISTRAR <u>JAN 13 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |  |  |

7:01 PM 15. 11/10/77

11/10/77 - 11:00 PM

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
 00317 CERTIFICATE OF DEATH 00320

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Hampden Baltimore</u> MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>1</u>                     |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belleville</u>   |  | c. LENGTH OF STAY IN 1b  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Milford Manor Nursing Home</u>   |  | d. STREET ADDRESS <u>3001 Chelsea Terrace</u>  |   |
| 3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>Kleeman</u> Last <u>Kleeman</u>  |  | 4. DATE OF DEATH Month <u>January</u> Day <u>6</u> Year <u>1967</u>  |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 8, 1886</u>                                |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>   | 11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>  |
| 13. FATHER'S NAME <u>Abraham Banberger</u>   |  | 14. MOTHER'S MAIDEN NAME <u>Theresia?</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |   |
| 17. INFORMANT <u>M. Segi Kleeman</u>   |  | Address <u>6701 Maureen Rd</u>   |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u><br>552x<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>                      |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , 19 <u>67</u> , to <u>Jan. 6, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 6, 1967</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE <u>Herbert Goldstone</u>  |  | 22b. DATE SIGNED <u>Jan. 7, 1967</u>   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>HERBERT GOLDSTONE M.D.</u>   |  | 22d. ADDRESS <u>3643 Blinggle Ave</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Jan 8/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY <u>Chesa Chas Chesa</u>   | 23d. LOCATION (City, town or county) (State) <u>Rondelltown, Md</u> |
| 24. FUNERAL DIRECTOR <u>Sol Leamon &amp; Son</u>   |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |   |
| ADDRESS <u>6010 Rest. Rd.</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |   |
| DATE JAN 11 1967   |  |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                  |  |   |  |   |  |   |  |  |  |
|---|--|----------------------------------|--|---|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH  |  |                                  |  |   |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |                                  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> |  |   |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>  |  |                                  |  |   |  | c. LENGTH OF STAY IN 1b   |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Shangri-La. Home 333 Harlem Lane</u>   |  |                                  |  |   |  | d. STREET ADDRESS<br><u>429 S. Augusta Ave.</u>   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Hilda</u> Middle <u>Klein</u> Last <u>Klein</u>   |  |                                  |  |   |  | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>23</u> Year <u>1967</u>  |  |   |  |  |  |
| 5. SEX<br><u>Female</u>   |  | 6. COLOR OR RACE<br><u>White</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>Oct. 22, 1888</u>  |  | 9. AGE (in years last birthday)<br><u>78</u> yrs.                 |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Sales Lady</u>  |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Dept. Store</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Balto. Md.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>                   |  |  |  |
| 13. FATHER'S NAME<br><u>Charles F. Schnappinger</u>   |  |                                  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Margaret Gischel</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  |                                  |  | 16. SOCIAL SECURITY NO.<br><u>219-20-8368</u>   |  | 17. INFORMANT<br>Address <u>Md.</u><br><u>Mr. E. Melvin Klein 12 Magruder Ave. Catonsville</u>  |  |   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Crown Thrombosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u><br>DUE TO (c) <u>12 Year</u> |  |                                  |  |   |  |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u>          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Complicated with deep August 1966 Urinary Infection</u>   |  |                                  |  |   |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                              |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> , 19 <u>67</u> , to <u>1/23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>1:55</u> AM, from the causes and on the date stated above.   |  |                                  |  |   |  |   |  |   |  |  |  |
| 22a. SIGNATURE<br><u>E. W. Johnson</u>  |  |                                  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>1/24/67</u>                                |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>E. W. JOHNSON</u>  |  |                                  |  |   |  | 22d. ADDRESS<br><u>3432 Frederick Ave (29)</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                                  |  | 23b. DATE THEREOF<br><u>Jan. 25, 1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cem.</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Balto. Md.</u> |  |  |  |
| 24. FUNERAL DIRECTOR<br><u>G. Truman Schwab 3512 Frederick Ave. Balto. Md.</u>  |  |                                  |  |   |  | 25a. REC'D BY REGISTRAR<br><u>J. Charles Judge</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>J. Charles Judge</u>             |  |  |  |
| DATE <u>JAN 26 1967</u>   |  |                                  |  |   |  |   |  |   |  |  |  |



FOR STATE  
HEALTH DEPT.

00319

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00322

|   |  |  |   |
|---|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town)<br><b>BALTIMORE 12</b>  |  | c. LENGTH OF STAY IN 1b<br><b>6 years</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>613 KINGSTON RD</b>  |  | d. STREET ADDRESS<br><b>613 KINGSTON RD</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br><b>SAMUEL ARDEN KNEPP</b>   |  | 4 DATE OF DEATH<br>Month <b>JAN.</b> Day <b>22</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>M</b>   | 6 COLOR OR RACE<br><b>W</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>6-10-26</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Manager</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Black &amp; Decker</b>   | 9 AGE (In years last birthday) yrs. <b>40</b>   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Curwensville, Pa.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Ira M. Knepp</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Rilla Johnston</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWII &amp; Korea</b>  |  | 16. SOCIAL SECURITY NO.<br><b>178-20-7982</b>  |   |
| 17. INFORMANT<br><b>Mrs. Patricia C. Knepp</b>  |  | Address<br><b>same as 2D</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1001 MYOCARDIAL INFARCTION</b><br>IMMEDIATE CAUSE (a) <b>1001</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____<br>DUE TO (c) _____   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |   |
| ACTUAL SIGNATURE <b>William A. Pillsbury</b> M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type) <b>William A. Pillsbury</b>  |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>William A. Pillsbury M.D.</b>   |   |
|   |  | Address (Street, city, town, or county) <b>1-22-67</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-25-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Crown Crest Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Clearfield Co. Pennsylvania</b>               |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson Inc.</b>  |  | ADDRESS<br><b>1050 York Rd.</b>  |   |
| 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PN3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |   |  |  |  |  |   |
|--|--|---|--|---|--|--|--|--|---|
| 00320  |  |   |  |   | 00323  |  |  |  |   |
| 1. PLACE OF DEATH  |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                      |  |  |  |   |
| a. COUNTY<br>BALTIMORE   |  |   |  |   | a. STATE<br>MARYLAND   |  |  |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>BALTIMORE  |  |   |  |   | b. COUNTY<br>BALT  |  |  |  |   |
| c. LENGTH OF STAY IN 1b<br>3 days  |  |   |  |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br>BALTIMORE, WHITE MARSH |  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br>GREATER BALTIMORE MEDICAL CENTRE   |  |   |  |   | d. STREET ADDRESS<br>#1 BIRD RIVER GROVE RD.   |  |  |  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |   |  |  |  |  |   |
| 3. NAME OF DECEASED (Type or print)  |  |   |  |   | 4. DATE OF DEATH   |  |  |  |   |
| First Middle Last<br>JOSHUA ELWOOD KNIGHT  |  |   |  |   | Month Day Year<br>JAN. 25 1967   |  |  |  |   |
| 5. SEX<br>M  |  | 6. COLOR OR RACE<br>W   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br>8-18-1901                                |  | 9. AGE (In years last birthday)<br>65 yrs. |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>FILM EDITOR   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br>Mo. Censors  |  | 11. BIRTHPLACE (County & State, or foreign country)<br>BALTIMORE, MD.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                       |  |  |   |
| 13. FATHER'S NAME<br>CLARENCE KNIGHT   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br>HILDA BENTON   |  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No  |  | 16. SOCIAL SECURITY NO.<br>214-20-5063  |  | 17. INFORMANT<br>Mrs Anna M. Knight Bird River Grove  |  | Address  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART I. DEATH WAS CAUSED BY:<br>1621 IMMEDIATE CAUSE (a) <i>Metastases</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Adenocarcinoma of lungs</i><br>DUE TO (c)                    |  |   |  |   |  |  |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                         |  |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from Jan. 23, 1967, to Jan. 25, 1967, that (I) (we) last saw the deceased alive on Jan. 25, 1967, and that death occurred at 10:15 M. from the causes and on the date stated above. |  |   |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br>M. Shabell Mac Geger   |  |   |  |   | 22b. DATE SIGNED<br>1-25-67  |  |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br>I. MAC GEGER   |  |   |  |   | 22d. ADDRESS<br>Greater Baltimore Med. Centre  |  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial  |  | 23b. DATE THEREOF<br>1-28-1967  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Abingdon Cemetery   |  | 23d. LOCATION (City, town or county) (State)<br>Abingdon Md. |  |  |   |
| 24. FUNERAL DIRECTOR<br>Lassahn Funeral Home 7401 Cedar Road   |  |   |  |   | 25a. REC'D BY REGISTRAR<br>DATE JAN 30 1967  |  | 25b. REGISTRAR'S SIGNATURE<br>Charles H. Geger |  |   |



FOR STATE  
HEALTH DEPT.

00321

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00324

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9 Patapsco Avenue</b>  |   | d. STREET ADDRESS<br><b>9 Patapsco Avenue</b>  |   |
| 3 NAME OF DECEASED (Type or print)<br>First<br><b>JOHN</b><br>Middle<br><b>EDWARD</b><br>Last<br><b>KOLB, Jr.</b>   |   | 4 DATE OF DEATH<br>Month<br><b>January</b><br>Day<br><b>1</b><br>Year<br><b>19 67</b>  |   |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>July 8, 1944</b>                                    |
| 9. AGE (in years lost birthday)<br><b>22 yrs</b>  |   | 10. IF UNDER 24 HRS<br>Months<br><b>22</b> Years<br><b>22</b> Days<br><b>22</b> Hours<br><b>22</b> Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MECHANIC</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CITY BOARD OF ED.</b>  |   |
| 11 BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>JOHN F. KOLB, Sr.</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>FREDA MARTIN</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |   | 16 SOCIAL SECURITY NO<br><b>218-42-0112</b>  |   |
| 17 INFORMANT<br><b>FREDA M. KOLB,</b>   |   | Address<br><b>SAME AS #2</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Acute Alcoholism</b><br>3220.<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO<br>(c) _____  |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br>19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |  |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m.<br>p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg, etc)  | 20f. (City or town) (County) (State)                                      |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><b>Rudiger Breitenecker, M.D.</b>   |   | 22. DATE SIGNED<br><b>2/1/67</b>   |   |
| EXAMINER'S NAME (Type)<br><b>Rudiger Breitenecker, M.D.</b>   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1/4/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BE LAIR MEMORIAL</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BE LAIR, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>W. BRADY'S BRADLEY, INC., DUNDALK</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 4 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. ...</b>                       |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00322

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00325

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                   |   |                                    |
|---|-----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND   |                                   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY                              |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                   | c. LENGTH OF STAY IN 1b<br><b>Catonsville</b>   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>502 Forest Lane</b>  |                                   | d. STREET ADDRESS<br><b>502 Forest Lane</b>   |                                    |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Jeanne Elizabeth KREBS</b>   |                                   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>12</b> Year <b>1967</b>   |                                    |
| 5. SEX<br><b>Female</b>   | 6. CO. OR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-25-22</b> |
| 9. AGE (in years last birthday) yrs <b>44</b>   |                                   | 10. F UNDER 1 YEAR Months <b>12</b> Days <b>19</b> Hours <b>67</b> Min  |                                    |
| 10a. US. AL. OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                   | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Vernon L. Knecht</b>  |                                   | 14. MOTHER'S M.A.D.E.N. NAME<br><b>Helen Matthews</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                   | 16. SOCIAL SECURITY NO<br><b>214-16-3338</b>  |                                    |
| 17. INFORMANT<br><b>Mr. Gerard Krebs</b><br><b>502 Forest Lane</b>  |                                   | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)   |                                   | INTERVAL BETWEEN ONSET AND DEATH  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 8)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                   | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect an <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                   |   |                                    |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b><br>EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |                                   | 22. DATE SIGNED<br><b>January 12, 1967</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                   | 23b. DATE THEREOF<br><b>1-16-67</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cem.</b>  |                                   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Witzke F.D.-4101 Edmondson Ave.</b>  |                                   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 16 1967</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                   |   |                                    |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00323

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LANS DOWNE</b><br>c. LENGTH OF STAY IN 1b<br><b>20 YR</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1714 HALL AVE 21227</b>  |  |  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LANS DOWNE</b><br>d. STREET ADDRESS<br><b>1714 HALL AVE</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3 NAME OF DECEASED (Type or print)<br><b>BERLINE BOWMAN KUHN</b><br>First Middle Last  |  |  |  | 4 DATE OF DEATH<br><b>JAN 2 19 67</b><br>Month Day Year  |  |  |  |
| 5 SEX<br><b>MALE</b>   |  | 6 COLOR OR RACE<br><b>WHITE</b>  |  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8 DATE OF BIRTH<br><b>NOV 20, 1910</b>   |  |
| 9 AGE (In years last birthday)<br><b>56</b> yrs  |  | 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SPRAY PAINTER</b> |  | 10b KIND OF BUSINESS OR INDUSTRY<br><b>MARTIN MFG.</b>   |  | 11 BIRTHPLACE (State or foreign country)<br><b>SMITHS BURG MD</b>                                |  |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |  |  | 13 FATHER'S NAME<br><b>ASA KUHN</b>  |  |  |  |
| 14 MOTHER'S MAIDEN NAME<br><b>JENNIE BOWMAN</b>  |  |  |  | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  |  |  |
| 16 SOCIAL SECURITY NO<br><b>220163487</b>  |  |  |  | 17 INFORMANT<br><b>MRS. MARY GRACE KUHN</b><br>Address<br><b>SAME ADDRESS</b>  |  |  |  |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>163X</b><br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____<br>DUE TO (c) _____   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>              |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)  |  |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John N. Snyder</b> M.D.<br>EXAMINER'S NAME (Type)<br><b>JOHN N. SNYDER</b>  |  |  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><b>6348 FREDERICK</b>  |  |  |  |
| 22a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 22b DATE THEREOF<br><b>1/5/67</b>  |  | 22c NAME OF CEMETERY OR CREMATORY<br><b>Blue Ridge</b>   |  | 22d LOCATION (City or Town) (County) (State)<br><b>Thurmont Md.</b>                              |  |
| 23 FUNERAL DIRECTOR<br><b>Raymond E. Croager</b>   |  |  |  | 24 REC'D BY REGISTRAR<br><b>Raymond E. Croager</b>   |  | 25 REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |
| DATE<br><b>JAN 5 1967</b>  |  |  |  | DATE<br><b>JAN 5 1967</b>  |  |  |  |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00324

## CERTIFICATE OF DEATH

00327

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>  |   | c. LENGTH OF STAY IN 1b<br><b>34 Days</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Veterans Administration Hospital</b>  |   | e. STREET ADDRESS<br><b>827 Hollins Street</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>ALFRED JAMES LA LOTTE</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 25 19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> <i>Separated</i> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/1/97</b>   |
| 9. AGE (In years last birthday) yrs<br><b>69</b>  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min   | 11. IF UNDER 24 HRS.<br>Months Days Hours Min   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Cook</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William LaLotte</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Reynolds</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>   |   | 16. SOCIAL SECURITY NO<br><b>217-05-93-66</b>  |   |
| 17. INFORMANT<br><b>Clinical Records, VA Hospital, Ft. Howard, Md.</b>  |   | Address  |   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>165X IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT LUNG</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost }<br>(b) DUE TO<br>(c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>12/22/ 19 66</b> to <b>1/25/ 19 67</b> , that <del>xx</del> (we) last saw the deceased alive on <b>1/25/ 19 67</b> , and that death occurred at <b>5:20A</b> M, from causes and on the date stated above.              |   |  |   |
| 22a. SIGNATURE<br><i>Peter J. Juvan</i>   |   | 22b. DATE SIGNED<br><b>1/25/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>PETER V. JUVAN, M. D.</b>  |   | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/27/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>John J. Cowan Funeral Home, Baltimore, Maryland</b>  |   | 25a. REC'D BY REGISTRAR<br><b>St</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in       . Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00325

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00328

Item 9 Film 4804 7/14/67 mh

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF BIRTH<br>a. COUNTY <u>Baltimore</u>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>BALTO-RURAL</u>   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>BALTO-RURAL</u>  |  |
| c. LENGTH OF STAY IN lb<br><u>16 yrs.</u>  |  | d. STREET ADDRESS<br><u>1842 YAKONA RD 34</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>1842 YAKONA RD 34</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><u>HARRY</u> First Middle Last   |  | 4. DATE OF DEATH<br><u>JANUARY 3</u> 19 <u>67</u> Month Day Year  |  |
| 5. SEX<br><u>MALE</u>  |  | 6. COLOR OR RACE<br><u>white</u>  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><u>April 6, 1983</u>  |  |
| 9. AGE (In years last birthday)<br><u>84</u> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months Days  |  |
| 11. IF UNDER 24 HRS.<br>Hours Min.   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>BRIDGE CRAPER</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>NURSERY</u>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>PENNSYLVANIA</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>   |  |
| 13. FATHER'S NAME<br><u>DAVID LANIGAN</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>ANNA ROLAND</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO. <u>187-01-5689</u>  |  |
| 17. INFORMANT<br><u>ALBERT G. LANIGAN</u>  |  | Address<br><u>1842 YAKONA RD</u>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ATHEROSCLEROSIS Cardiovascular Disease</u><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Duodenal Ulcer</u> |  |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                     |  |   |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><u>John C. Hyle</u><br><u>JOHN C. HYLE</u>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)<br><u>1-3-67</u> |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 22b. DATE THEREOF<br><u>1/5/67</u>  |  |
| 22c. NAME OF CEMETERY OR CREMATORY<br><u>McGowan Memorial</u>  |  | 22d. LOCATION (City, town, or county) (State)<br><u>Baltimore Mo.</u>   |  |
| 23. FUNERAL DIRECTOR<br><u>William E. Johnson</u>  |  | 24a. REC'D BY REGISTRAR<br><u>1967</u>  |  |
| 24b. REGISTRAR'S SIGNATURE<br><u>William E. Johnson</u>  |  | 24c. JUDGE<br><u>William E. Johnson</u>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

003226

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00329

|   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b><br>c. LENGTH OF STAY IN b.<br><b>23 mo'</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b><br>d. STREET ADDRESS<br><b>1915 W. Lombard St</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>Mary</b><br>Middle<br><b>Margaret</b><br>Last<br><b>Lau</b>  |  | 4. DATE OF DEATH<br>Month<br><b>1</b><br>Day<br><b>2</b><br>Year<br><b>1967</b> |  | 5. SEX<br><b>F</b>   |  | 6. COLOR OR RACE<br><b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2-9-37</b>            |  | 9. AGE (In years last birthday)<br><b>29</b> yrs.  |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>        |  |  |  |
| 13. FATHER'S NAME<br><b>Joseph O'Halloran</b>   |  |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Shanahan</b>                   |  |   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>216-34-3459</b>  |  |  |  | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b><br>Address   |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pulmonary Tuberculosis</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Empyema Thoracic Right.</b> |  |   |  |  |  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2-10-1964</b> , to <b>1-2-1967</b> , that (I) (we) last saw the deceased alive on <b>1-2-1967</b> , and that death occurred at <b>11:48</b> A.M. from the causes and on the date stated above.   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>   |  |   |  |  |  |  |  |   |  |  |  | 22b. DATE SIGNED<br><b>1-2-67</b>                  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>   |  |   |  |  |  |  |  |   |  |  |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |  | 23b. DATE THEREOF<br><b>Jan. 6 1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lakeview Cemetery</b>         |  |   |  | 23d. LOCATION (City, town or county) (State) |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Thas, Inc 1000 Hollins St. Balt. Md.</b>   |  |   |  |  |  |  |  |   |  |  |  |  |  |  |  |
| 25a. REC'D BY REGISTRAR<br><b>JAN 5 1967</b>  |  |   |  |  |  |  |  |   |  |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |  |  |  |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00327

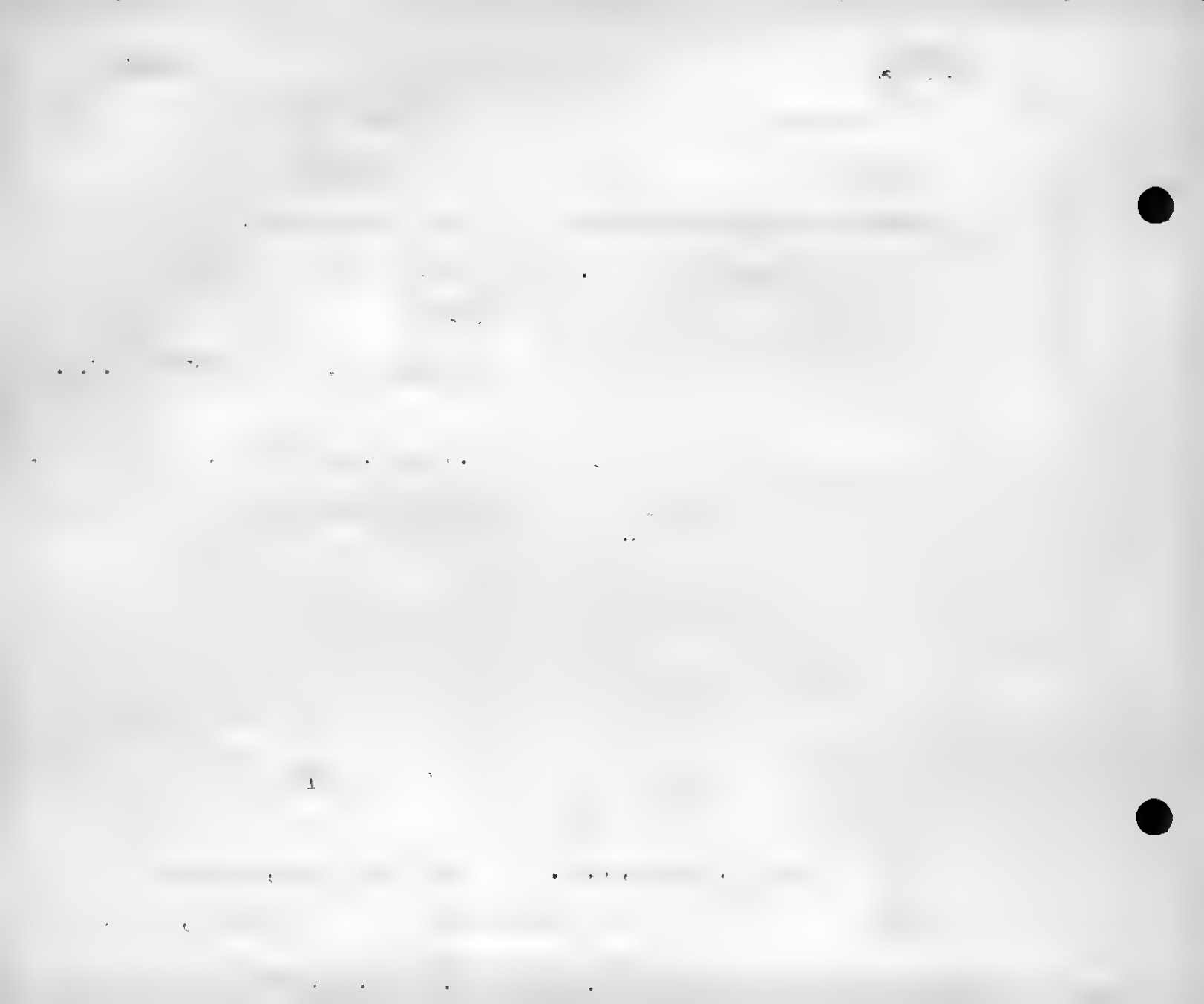
CERTIFICATE OF DEATH

00331

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                 |  |  |  |   |   |  |
|--|---------------------------------|--|--|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                                 |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY           |   |   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |                                 | c LENGTH OF STAY IN 'b<br><b>65 DAYS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>                                 |   |   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |                                 |  |  | d STREET ADDRESS<br><b>2001 PENROSE AVENUE</b>   |   | e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>STEPHEN</b> Middle <b>W.</b> Last <b>LeCRAFT</b>  |                                 |  | 4 DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>12</b> Year <b>1967</b> |  |   |   |  |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>NEGRO</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4/15/89</b>                                     |  | 9 AGE (In years last birthday) yrs. <b>77</b> | IF UNDER 1 YEAR<br>Months Days Hours Min  | IF UNDER 24 HRS<br>Hours Min   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Bakery</b>   |  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>SPRING HILL, NORTH CAROLINA U.S.A.</b>                                      |   | 12 CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>  |                                 |  |  | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>   |   |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |                                 | 16. SOCIAL SECURITY NO<br><b>215 07 53 52</b>  |  | 17. INFORMANT Address<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |   |   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE WITH METASTASES TO LIVER, LUNGS AND HIP BONES</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>DUE TO<br>DUE TO<br>DUE TO |                                 |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>UNKNOWN</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |  |  |   |   | 19. WAS ALTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |  |   |   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                 | 20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work  |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>11/18/66</b> , 19 <b>to</b> <b>1/12/67</b> , 19 <b>that</b> <del>we</del> (we) last saw the deceased alive on <b>1/12/67</b> , 19 <b>and that death occurred at</b> <b>9:15 AM</b> <b>from causes and on the date stated above</b>                                |                                 |  |  |  |   |   |  |
| 22a SIGNATURE<br><i>Howard C. Kramer</i>   |                                 |  |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |   | 22b. DATE SIGNED<br><b>1/12/67</b>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>HOWARD C. KRAMER, M. D.</b>  |                                 |  |  | 22a ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                 | 23b DATE THEREOF<br><b>1/16/1967</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |   | 23d LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                    |  |
| 24. FUNERAL DIRECTOR<br><i>Charles Judge</i>   |                                 |  |  | ADDRESS<br><b>HAYES FUNERAL HOME</b>   |   | 25a REC'D BY REGISTRAR<br><b>DATE JAN 17 1967</b>   |  |
|  |                                 |  |  |  |   | 25b REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00328

## CERTIFICATE OF DEATH

00330

|   |   |   |   |  |   |  |  |
|---|---|---|---|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>c. LENGTH OF STAY IN 1b<br><b>YEARS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>810 REGIS COURT</b>   |   |   |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>d. STREET ADDRESS<br><b>8224 FT. SMALLWOOD RD.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First<br><b>REBECCA</b><br>Middle<br><b>T.</b><br>Last<br><b>LAWTON</b>  |   | 4. DATE OF DEATH<br>Month<br><b>I</b><br>Day<br><b>15</b><br>Year<br><b>19 67</b>   |   |  |   |  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>II/4/1896</b>                                  | 9. AGE (In years last birthday)<br><b>70</b> yrs.  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min.                                      |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>MARYLAND</b>   |   |  |  |
| 13. FATHER'S NAME<br><b>WILLIAM BIDDISON</b>  |   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                         |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>NO</b>  |   |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                                |  | 17. INFORMANT<br><b>MRS. DORIS L. COLE</b><br>Address<br><b>810 REGIS CT. BALTIMORE</b> |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>170X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>QUE TO (b) <u>Metastatic Carcinoma of Breast.</u><br>QUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u><br><u>2 years</u>                    |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |   |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)<br><b>BALTIMORE</b>                               | (County) (State)   |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 19 <u>65</u> , to <u>January</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>January 15</u> , 19 <u>67</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.  |   |   |   |  |   |  |  |
| 22a. SIGNATURE<br><u>E. Roderick Shipley</u>  |   | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><u>1-17-67</u>   |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>E. Roderick Shipley, M.D.</b>  |   | 22d. ADDRESS<br><b>529 Camp Meade Rd., Linthicum, Md.</b>   |   |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1/18/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEADOWRIDGE CEMETERY</b>   | 23d. LOCATION (City, town or county) (State)<br><b>BALTIMORE, MD.</b> |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>McColly F.H.</b>   |   | ADDRESS<br><b>237 Patapsco Ave.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 18 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                                      |  |  |



00329

## CERTIFICATE OF DEATH

00332

|  |                                 |  |   |
|--|---------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>11/23/67</b>  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21214</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |                                 | d. STREET ADDRESS<br><b>6113 Tramore Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Anna Marie LEE</b>  |                                 | 4 DATE OF DEATH<br>Month Day Year<br><b>January 20, 1967</b>   |   |
| 5 SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><b>November 8, 1903</b> |
| 9 AGE (In years last birthday)<br><b>63 yrs.</b>   |                                 | 10. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |                                 | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |   |
| 12 CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                                 | 13. FATHER'S NAME<br><b>John Bauman</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Lohman</b>   |                                 | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   |
| 16. SOCIAL SECURITY NO.<br><b>213-03-2584</b>  |                                 | 17 INFORMANT<br><b>Mrs. Cynthia Rohde</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio-Respiratory Arrest</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Obstruction of the Pulmonary Conus by Mural Thrombus in Right Ventricle</b><br>DUE TO<br>(c) |                                 | INTERVAL BETWEEN ONSET AND DEATH   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                 |  |   |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                 | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |                                 | 20c. TIME OF INJURY Month, Day, Year<br>Hour o m. p.m. <b>19</b>   |   |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                 | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   |
| 20f. (City or town) (County) (State)   |                                 | 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>12/9/</b> 19 <b>66</b> , to <b>1/20/</b> 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/20/</b> 19 <b>67</b> , and that death occurred at <b>1:30PM</b> , from causes and on the date stated above. |   |
| 22a. SIGNATURE<br><b>Dr. Reynaldo Orjuela-Gomez M.D.</b>   |                                 | 22b. DATE SIGNED<br><b>January 20, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Reynaldo Orjuela-Gomez M.D.</b>   |                                 | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                 | 23b. DATE THEREOF<br><b>1/23/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cem.</b>   |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |                                 | 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. Ruck</b>   |                                 |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00330

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00333

|  |                                   |  |   |  |  |  |  |
|--|-----------------------------------|--|---|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                   |  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Chester</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |                                   |  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Kennedy Hwy. near White Marsh Blvd.</b>   |                                   |  |   | d. STREET ADDRESS<br><b>364 Lamokin St.</b>  |  |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Lorenzo</b> Middle <b>Lee</b> Last <b>Lee</b>   |                                   |  |   | 4 DATE OF DEATH<br>Month <b>1</b> Day <b>21</b> Year <b>19 67</b>  |  |  |  |
| 5 SEX<br><b>male</b>   | 6 COLOR OR RACE<br><b>colored</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>March 11 1944</b> | 9 AGE (In years lost birthday)<br><b>22</b> yrs  | IF UNDER 1 YEAR<br>Months <b>03</b> Days <b>11</b> | F UNDER 24 HRS<br>Hours <b>11</b> Min <b>00</b>                          |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>  |                                   | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11 BIRTHPLACE (State or foreign country)<br><b>n.e.</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                             |  |
| 13. FATHER'S NAME<br><b>Alton Roberta</b>  |                                   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Alberta Lee</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                   | 16. SOCIAL SECURITY NO   |   | 17. INFORMANT<br><b>Alberta Perry Williamson n.e.</b> Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>P19 H</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>(c)   |                                   |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                   |  |   |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Passenger in auto into fixed object</b>                   |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>4:46</b> <del>xxx</del> <b>1</b> <b>21</b> <b>19 67</b>   |                                   | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input checked="" type="checkbox"/> of work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>street</b>  |  | 20f. (City or town) (County) (State)<br><b>Baltimore Md.</b>             |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                   |  |   |  |  |  |  |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz, M.D.</b>   |                                   | 22. DATE SIGNED<br><b>1/21/67</b>  |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>1-26-67</b>  |  |  |  |
| EXAMINER'S NAME (Type)<br><b>Werner U. Spitz, M.D.</b>   |                                   | 23b. DATE THEREOF  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>See cem</b>   |  | 23d. LOCATION (City or town) (County) (State)<br><b>Williamston n.e.</b> |  |
| 24. FUNERAL DIRECTOR<br><b>Sis. W. Nelson 1348 n. Calhoun St</b>   |                                   | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 23 1967</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Young</b>   |  |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, marking the word "pending" in parentheses in paragraph 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00331

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00334

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |                                    |   |                                    |
|---|------------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Pennsylvania</b> b. COUNTY <b>Philadelphia</b>         |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                    | c. LENGTH OF STAY IN 1b   |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Kennedy Hwy. nr. White Marsh Blvd.</b>   |                                    | d. STREET ADDRESS<br><b>6147 Spruce St.</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br><b>Louis Lee</b>   |                                    | 4. DATE OF DEATH<br><b>1 21 19 67</b>   |                                    |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>colored</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12-5-26</b> |
| 9. AGE (In years last birthday) yrs.<br><b>40</b>   |                                    | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Salvage</b>  |                                    | 12. C. T. ZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>Romus Lee</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Alice Knight</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                    | 16. SOCIAL SECURITY NO  |                                    |
| 17. INFORMANT<br><b>Alberta Perry Williamson n.c.</b>   |                                    | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Multiple injuries</b><br>DUE TO<br>(b)<br>DUE TO<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  |                                    |   |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    |   |                                    |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)<br><b>driver of auto into fixed object</b>                       |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>4:46 1 21 19 67</b>  |                                    | 20d. INJURY OCCURRED <input checked="" type="checkbox"/> While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>       |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><b>street</b>   |                                    | 20f. (City or town) (County) (State)<br><b>Balto. Md.</b>   |                                    |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input type="checkbox"/> inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                    |   |                                    |
| ACTUAL SIGNATURE<br><b>Werner U. Spitz M.D.</b>   |                                    | 22. DATE SIGNED<br><b>1/21/67</b>   |                                    |
| EXAMINER'S NAME (Type)  |                                    | Address (Street, city, town, or county)   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>1-26-67</b>   |                                    | 23b. DATE THEREOF   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee Cem</b>  |                                    | 23d. LOCATION (City or Town) (County) (State)<br><b>Williamston n.c.</b>  |                                    |
| 24. FUNERAL DIRECTOR<br><b>Leo D. Nelson 1348 n. Calhoun St</b>   |                                    | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Werner U. Spitz</b>  |                                    |   |                                    |



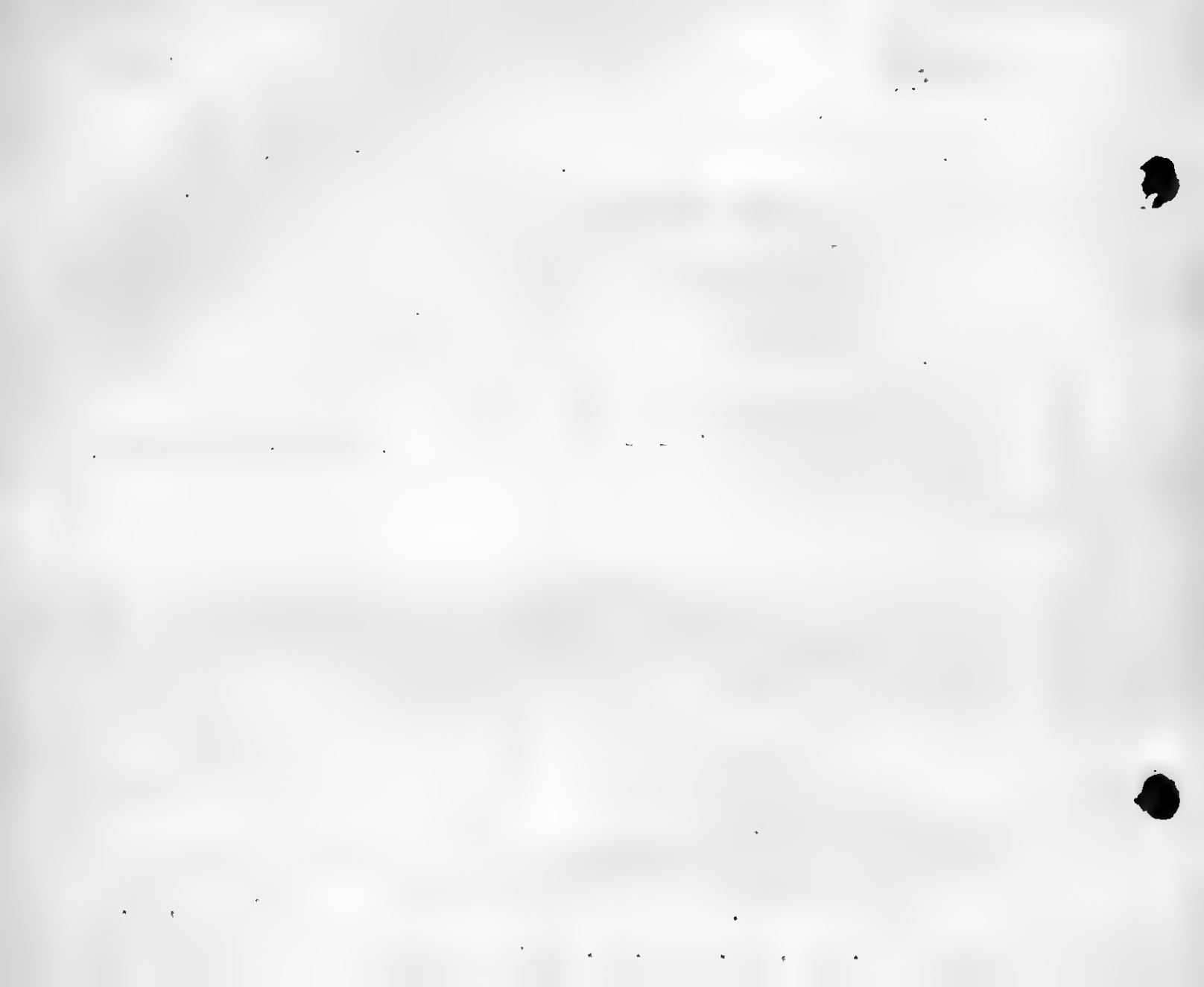


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |  |  |  |  |  |
| 00332  |  |  |  |  | 00335  |  |  |  |  |
| 1. PLACE OF DEATH  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)                      |  |  |  |  |
| a. COUNTY<br><b>Baltimore County</b>   |  |  |  |  | a. STATE<br><b>Maryland</b>  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson</b>  |  |  |  |  | b. COUNTY<br><b>Baltimore</b>  |  |  |  |  |
| c. LENGTH OF STAY IN 1b<br><b>9 days</b>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21213</b> |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>   |  |  |  |  | d. STREET ADDRESS<br><b>1711 N. Freedomway Balt. 13, Md.</b>   |  |  |  |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <b>Paul (Paolo)</b>  |  |  |  |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>29</b> Year <b>1967</b>                                       |  |  |  |  |
| 5. SEX<br><b>M</b>   |  |  |  |  | 6. COLOR OR RACE<br><b>W.</b>  |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  | 8. DATE OF BIRTH<br><b>6-25-84</b>   |  |  |  |  |
| 9. AGE (In years last birthday)<br><b>82</b>   |  |  |  |  | 10. IF UNDER 1 YEAR (If UNDER 24 HRS. Months Days Hours Min.)  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steel Worker</b>   |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Italy</b>  |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Geatano Letra</b>  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>? Unknown</b>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |  |  |  | 16. SOCIAL SECURITY NO. (If yes give war or dates of service)<br><b>213-07-2922</b>                        |  |  |  |  |
| 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>   |  |  |  |  | Address  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Broncho-pneumonia</b><br>4771X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Fibrosis with undetermined Origin</b> |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |
| 20a. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |  |  |  | 20b. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |  |  |
| 20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-20, 1967</b> to <b>1-29, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-29, 1967</b> , and that death occurred at <b>2:15 PM</b> , from the causes and on the date stated above.  |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>  |  |  |  |  | 22b. DATE SIGNED<br><b>1-29-67</b>   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>  |  |  |  |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |  |  |  | 23b. DATE THEREOF<br><b>2/1/67</b>   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  |  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Md.</b>                                      |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Buck, Inc. Baltimore, Md. 21214</b>  |  |  |  |  | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 31 1967</b>   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |  |  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO MINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (The permit should be removed from the certificate and placed in the burial-transit permit. The permit should be removed from the certificate and placed in the burial-transit permit. The permit should be removed from the certificate and placed in the burial-transit permit.)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |   |  |   |  |
|--|--|--|--|--|---|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |   |  |   |  |
| 00333  |  |  |  |  | 00336   |   |  |   |  |
| 1. PLACE OF DEATH  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)             |   |  |   |  |
| a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |  |  | a. STATE <u>Maryland</u> b. COUNTY  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Foxleigh Nursing Home</u>  |  |  |  |  | d. STREET ADDRESS <u>3301 Timberfield Lane #8</u>   |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Samuel</u> First Middle Last  |  |  |  |  | 4. DATE OF DEATH Month <u>1</u> Day <u>9</u> Year <u>1967</u>                                     |   |  |   |  |
| 5. SEX <u>Male</u>   |  | 6. COLOR OR RACE <u>White</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <u>Sept. 19, 1893</u>                                  |  | 9. AGE (In years last birthday) <u>73</u> yrs.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tailor</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shop</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                 |  | 13. FATHER'S NAME <u>Unknown</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |  | 16. SOCIAL SECURITY NO. <u>217-03-3241</u>   |  | 17. INFORMANT <u>Mrs. Tina Liberman</u>  |   | Address <u>3301 Timberfield Lane</u>                                    |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>331X<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis</u><br>DUE TO (c) <u>Urinary Tract Infection</u> |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |   |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                                    |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21. I certify that (1) (this hospital) attended the deceased from <u>11-28</u> , 19 <u>66</u> , to <u>1-9</u> , 19 <u>67</u> , that (2) (we) last saw the deceased alive on <u>1-9</u> , 19 <u>67</u> , and that death occurred at <u>9:00</u> PM, from the causes and on the date stated above. |  |  |  |  |   |   |  |   |  |
| 22a. SIGNATURE <u>David J. Miller</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>   |  |  |  |  | 22b. DATE SIGNED <u>1-9-67</u>  |   |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>David J. Miller</u>  |  |  |  |  | 22d. ADDRESS <u>Linson Rd. Owings Mills Md</u>  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1/11/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>   |   | 23d. LOCATION (city, town or county) (State) <u>Baltimore, Maryland</u> |  |   |  |
| 24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reisterstown Rd.</u> ADDRESS   |  |  |  |  | 25a. REC'D BY REGISTRAR <u>16</u> DATE <u>1967</u>  |   | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> |   |  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00334

## CERTIFICATE OF DEATH

00337

|   |  |  |                         |   |  |   |   |
|---|--|--|-------------------------|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  |  |                         | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u></u>                          |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore (Rural)</u>  |  |  | c. LENGTH OF STAY IN 1b |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 21214</u> |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>St. Joseph Hospital</u>  |  |  |                         | d. STREET ADDRESS<br><u>2715 Beechland Ave.</u>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>John</u> Middle <u>F.</u> Last <u>Lidinsky</u>  |  |  |                         | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>9</u> Year <u>19 67</u>   |  |   |   |
| 5. SEX<br><u>male</u>   |  | 6. COLOR OR RACE<br><u>white</u>   |                         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>8/4/09</u>   |   |
| 9. AGE (In years last birthday)<br><u>57</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bureau of Parks</u> |                         | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>City of Baltimore</u>   |  | 11. BIRTHPLACE (County & State or foreign country)<br><u>Maryland</u>                             |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  | 13. FATHER'S NAME<br><u>Frank Lidinsky</u>   |                         | 14. MOTHER'S MAIDEN NAME<br><u>Mary Hora</u>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |  | 16. SOCIAL SECURITY NO<br><u>217-16-4512</u>   |                         | 17. INFORMANT<br><u>Mrs. Mary A. Lidinsky</u>   |  | Address<br><u>(Same)</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Metastatic Cancer (squamous cell)</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b) _____<br>(c) _____ |  |  |                         |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |                         |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |                         | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. _____ p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |                         | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <del>(it)</del> (this hospital) attended the deceased from <u>Jan. 2</u> , 19 <u>67</u> , to <u>Jan. 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9</u> , 19 <u>67</u> , and that death occurred at <u>5.45 M.</u> from causes and on the date stated above.  |  |  |                         |   |  |   |   |
| 22a. SIGNATURE<br><u>Ramon P. Lopez</u>   |  |  |                         | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                        |  | 22b. DATE SIGNED<br><u>1/9/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Ramon P. Lopez</u>   |  |  |                         | 22d. ADDRESS<br><u>7620 York Rd. Baltimore, Md. 21204</u>   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 23b. DATE THEREOF<br><u>1/13/67.</u>   |                         | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Redeemer Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |   |
| 24. FUNERAL DIRECTOR<br><u>Leonard J. Ruck Inc. Balto. Md. 21214</u>  |  |  |                         | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 11 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages should be removed from the certificate and filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00335 CERTIFICATE OF DEATH 00338

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u><br>c. LENGTH OF STAY IN b<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>614 NORTHBEND RD</u>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>BALTIMORE</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u><br>d. STREET ADDRESS <u>614 NORTHBEND RD</u> |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 3. NAME OF <u>SARAH</u><br>(Type or print) First Middle Last   |  | 4. DATE OF DEATH <u>JAN 9 1967</u><br>Month Day Year  |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH <u>1-13-1887</u>  |  | 9. AGE (In years last birthday) <u>54</u> ym.   |  | 10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  | 13. FATHER'S NAME <u>JOHN G SHAW</u>  |  | 14. MOTHER'S MAIDEN NAME <u>AMELIA WAIPNER</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT <u>WALTER LINTHICUM 614 NORTHBEND RD</u>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u><br>DUE TO (b) <u>Arteriosclerotic cardio vascular</u><br>DUE TO (c) <u>disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).   |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  |
| 20f. (City or town)  |  | (County)  |  | (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u>60</u> , to <u>Jan 9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 6</u> , 19 <u>67</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.  |  |   |  |  |  |
| 22a. SIGNATURE <u>Homar U. Todd</u>  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Homar U. Todd</u>  |  | 22d. ADDRESS <u>2108 St Paul St</u>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  | 23b. DATE THEREOF <u>1-11-1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MT CLIVET CEM.</u>   |  |
| 23d. LOCATION (City, town or county) <u>FREDERICK RD</u>   |  | (State) <u>MD.</u>  |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>WEBER FUNERAL HOME 5312 EDMONDSON AVE</u>  |  | 25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

00336

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film 6384 1/1/67 mh

CERTIFICATE OF DEATH

Item 2b Film 6385 1/14/67 mh

00339

|  |   |  |   |
|--|---|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <u>BALTO.</u> MARYLAND  |   | 2 USUAL RESIDENCE where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> b COUNTY <u>Howard</u> ✓                       |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u>  |   | c. LENGTH OF STAY IN 1b<br><u>WOODSTOCK</u>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>RIDGEWAY MANOR</u>   |   | d. STREET ADDRESS<br><u>LEE Co. VA.</u>  |   |
| 3 NAME OF DECEASED (Type or print) <u>PETER N. LIVESAY</u>   |   | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>9</u> Year <u>1967</u>   |   |
| 5 SEX <u>M</u>   | 6 COLOR OR RACE <u>W</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-9-1895</u>  |
| 10a. SOCIAL OCCUPATION (Give kind of work done during most of work life even if retired)<br><u>Labor</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>FARM</u>   | 9 AGE (In years last birthday) yrs <u>71</u>  |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>LEE Co. VA.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><u>JEB LIVESAY</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>ADELINE PEARSON</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16 SOCIAL SECURITY NO. <u>226-16-2492</u>  |   |
| 17. INFORMANT<br><u>Robert Bryant</u>  |   | Address <u>Woodstock Md.</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Hypertension</u><br>DUE TO<br>(c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 day</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>none</u>   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>0</u> m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8 Jan</u> , 1967, to <u>9 Jan</u> , 1967 that (I) (we) saw the deceased alive on <u>9 Jan</u> 1967, and that death occurred at <u>2:57 PM</u> , from causes and on the date stated above  |   |  |   |
| 22a. SIGNATURE<br><u>William B. ...</u>  |   | 22b. DATE SIGNED<br><u>18 Jan 67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>William B. ...</u>  |   | 22d. ADDRESS<br><u>1334 ...</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>1-13-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Glenwood Baptist</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Glenwood Md.</u>                              |
| 24. FUNERAL DIRECTOR<br><u>F. C. HIGGINBOTHAM, ELLICOTT CITY, MD.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>DATE JAN 16 1967</u>   |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, within any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

| MAYLAND STATE DEPARTMENT OF HEALTH  |  |   |  |   |   |  |  |   |  |  |  |   |  |  |
|---|--|---|--|---|---|--|--|---|--|--|--|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |   |  |   |   |  |  |   |  |  |  |   |  |  |
| 00337   |  |   |  |   | CERTIFICATE OF DEATH  |  |  |   |  | 00340  |  |   |  |  |
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b> |  |  |   |  |  |  |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>   |  |   |  |   | c. LENGTH OF STAY IN TB<br><b>1 1/2 years</b>   |  |  |   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Warwick</b> |  |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>  |  |   |  |   | d. STREET ADDRESS   |  |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Teresa</b> Middle <b>Lee</b> Last <b>LOCKWOOD</b>  |  |   |  |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>17</b> Year <b>19 67</b>  |  |  |   |  |  |  |   |  |  |
| 5 SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>        |  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8 DATE OF BIRTH<br><b>5-29-64</b>  |  | 9 AGE (In years last birthday) yrs <b>2</b>   |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>17</b>  |  | IF UNDER 24 HRS<br>Hours <b>19</b> Min. <b>67</b> |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><b>Dependent</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Cecil Co., Maryland</b> |  |   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  |  |
| 13 FATHER'S NAME<br><b>John Howard Lockwood</b>   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Esther Amy RIDGLEY</b>   |  |  |   |  |  |  |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |   |  | 16. SOCIAL SECURITY NO<br><b>none</b>   |   | 17. INFORMANT<br><b>Rosewood Records, Owings Mills, Maryland</b>                 |  |   |  | Address  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br><b>471X</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c) DUE TO                      |  |   |  |   |   |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Severe mental retardation</b>  |  |   |  |   |   |  |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |  |  |   |  |  |  |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)           |  | 20f. (City or town) (County) (State)          |  |  |  |   |  |  |
| 21. I certify that <del>the</del> (this hospital) attended the deceased from <b>4-19-</b> <b>1965</b> to <b>1-17-</b> <b>1967</b> , that <del>we</del> (we) last saw the deceased alive on <b>1-17</b> <b>19 67</b> , and that death occurred at <b>9:15 A.M.</b> on <b>1-17-67</b> from causes and on the date stated above. |  |   |  |   |   |  |  |   |  |  |  |   |  |  |
| 22a. SIGNATURE<br><i>[Signature]</i>  |  |   |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>                       |   |  |  | 22b. DATE SIGNED<br><b>1-17-68</b>            |  |  |  |   |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Zsolt Koppanyi, M.D.</b>   |  |   |  | 22d. ADDRESS<br><b>Rosewood St. Hosp., Owings Mills, Md.</b>  |   |  |  |   |  |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  | 23b. DATE THEREOF<br><b>Jan 20 1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Basis Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Wheatland, Maryland</b>      |  |   |  |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br><b>Edward Fellows</b>   |  |   |  | ADDRESS<br><b>Millington, Md</b>  |   |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 20 1967</b> |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |  |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**00338** **CERTIFICATE OF DEATH** **00341**

|   |                                  |   |  |  |  |  |   |
|---|----------------------------------|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>HARRISONVILLE</u>  |                                  |   |  | c. LENGTH OF STAY IN 1b  |  |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>CHAPEL HILLS NURSING HOME</u>  |                                  |   |  | d. STREET ADDRESS<br><u>Dover Road</u>   |  |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Marian</u> Middle <u>Carney</u> Last <u>Long</u>  |                                  |   |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>9</u> Year <u>1967</u>   |  |  |   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 1, 1895</u> | 9. AGE (In years last birthday)<br><u>71</u> yrs.  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                               |   |
| 13. FATHER'S NAME<br><u>Albert I. Carney</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Chenoweth</u>  |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |                                  | 16. SOCIAL SECURITY NO.<br><u>None</u>  |  | 17. INFORMANT<br><u>Family Records</u>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Copon by the automatic machine.</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Myocardial infarction + atherosclerosis</u><br>DUE TO (c) <u>Exhaustion + stress</u> |                                  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>✓</u>  |                                  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)<br><u>✓</u>  |  |  |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour e.m. p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                     |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-4-67</u> , 19 <u>67</u> to <u>1-9-67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-4-67</u> , 19 <u>67</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.   |                                  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><u>[Signature]</u>  |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |  | 22b. DATE SIGNED<br><u>1-11-67</u>                                       |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>John C. Burns</u>  |                                  |   |  | 22d. ADDRESS<br><u>1224 E. 11th St.</u>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Jan. 12, 1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Grace Falls Rd. Meth. Cem.</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Cockeysville, Md.</u> |   |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>   |                                  |   |  | 25a. REC'D BY REGISTRAR<br><u>[Signature]</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>                       |   |

DATE JAN 13 1967

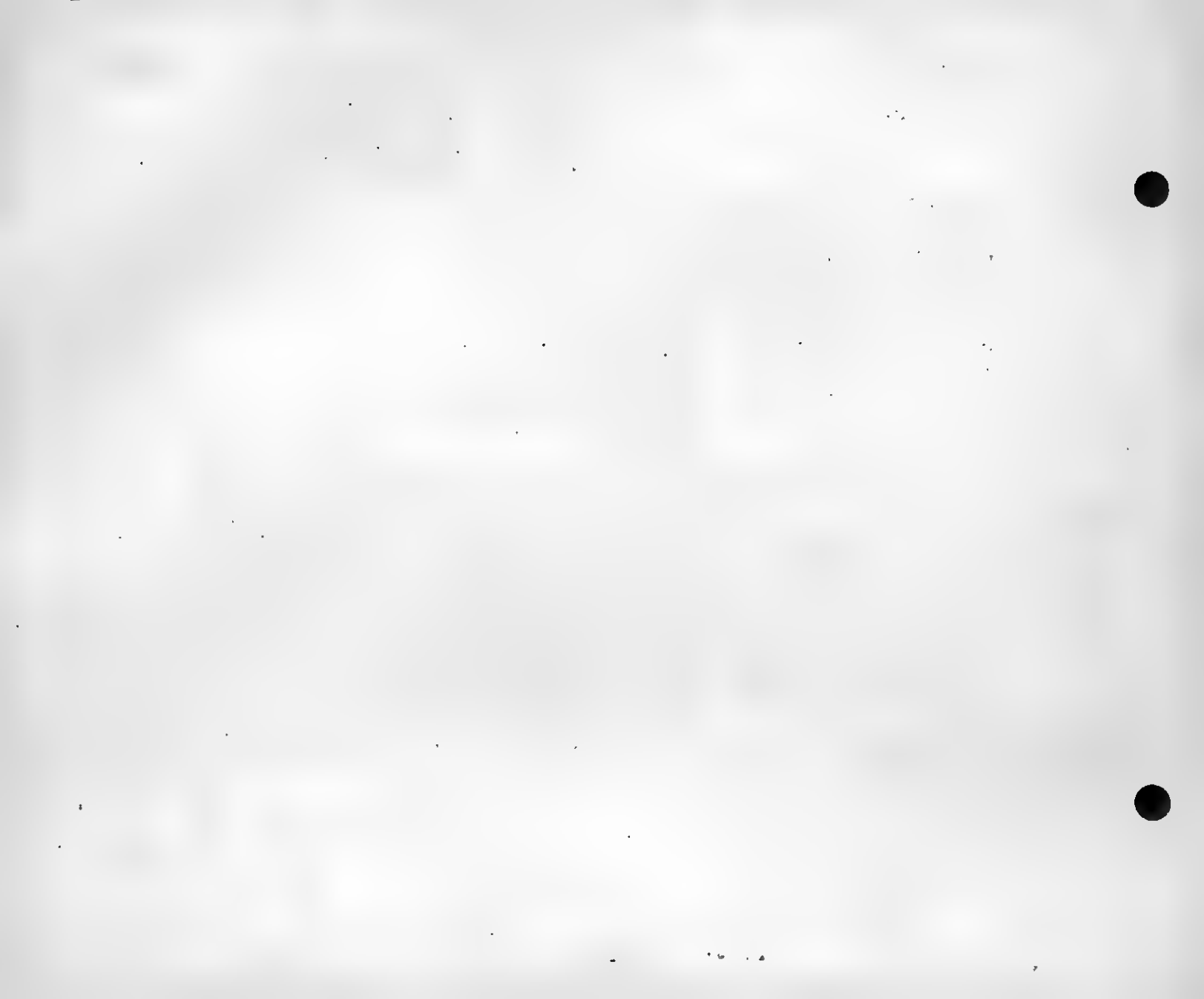


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                             |  |  |  |  |  |  |  |   |  |
|--|--|-----------------------------|--|--|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |                             |  |  |  |  |  |  |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |  |                             |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u> |  |  |  |   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>  |  |                             |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>  |  |  |  |   |  |
| c. LENGTH OF STAY IN 1b <u>32 1/2 min</u>  |  |                             |  |  |  | d. STREET ADDRESS <u>4240 THORNDLEIFE RD.</u>  |  |  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>   |  |                             |  |  |  |  |  |  |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>IRENE ANN LOTT</u>  |  |                             |  |  |  | 4. DATE OF DEATH <u>JANUARY 8 1967</u>   |  |  |  |   |  |
| 5. SEX <u>FEM</u>  |  | 6. COLOR OR RACE <u>CAU</u> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>3-19-05</u>  |  | 9. AGE (in years last birthday) <u>61</u> yrs.                       |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INS. EXAMINER</u>   |  |                             |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>PATTERSON, N.J.</u>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                     |  |
| 13. FATHER'S NAME <u>WILLIAM FOLEY</u>   |  |                             |  |  |  | 14. MOTHER'S MAIDEN NAME <u>LILLIAN ANN QUINN</u>  |  |  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |                             |  |  |  | 16. SOCIAL SECURITY NO. <u>UNK 21-217 02 PT. CHART</u>   |  |  |  |   |  |
| 17. INFORMANT <u>Ann Krueger</u> Address <u>711 50th St. d</u>   |  |                             |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |  |   |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>   |  |                             |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>   |  |  |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic adenocarcinoma of mediastinum</u>   |  |                             |  |  |  | (c) <u>Probably Carcinoma of the Lung</u>  |  |  |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                             |  |  |  |  |  |  |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                             |  |  |  |  |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                             |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |                             |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                 |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/7/</u> , 19 <u>67</u> , to <u>1/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/8</u> , 19 <u>67</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above. |  |                             |  |  |  |  |  |  |  |   |  |
| 22a. SIGNATURE <u>Juan L. Roque</u>  |  |                             |  |  |  | 22b. DATE SIGNED <u>1-8-67</u>   |  |  |  |   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>JUAN L. ROQUE</u>  |  |                             |  |  |  | 22d. ADDRESS <u>6701 N. Charles St. Balto 4 Md.</u>  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                             |  | 23b. DATE THEREOF <u>1-10-1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Baltimore Co. d.</u> |  |   |  |
| 24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road</u>  |  |                             |  |  |  | 25a. REC'D BY REGISTRAR <u>(34)</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>                   |  |   |  |
| DATE <u>JAN 10 1967</u>  |  |                             |  |  |  |  |  |  |  |   |  |





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00340

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00343

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTO</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX 13.</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>623 FRANKLIN</b>   |   | d. STREET ADDRESS<br><b>623 FRANKLIN</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>ROY LOWERS</b>  |   | 4. DATE OF DEATH<br>Month <b>JAN</b> Day <b>30</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 26 1891</b> 75 yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>75</b>  |
| 11. BIRTHPLACE (State or foreign country)<br><b>PA.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><b>SAM B. LOWERS</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>UNK</b>  |   | 16. SOCIAL SECURITY NO<br><b>—</b>  | 17. INFORMANT<br><b>LOWERS</b> Address <b>623 FRANKLIN</b>  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>42011 Acute Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b><br>(c)   |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))<br><b>Previous CVA</b>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |   |
| ACTUAL SIGNATURE <b>Theo C. Patterson</b> M.D.  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |
| EXAMINER'S NAME (Type) <b>THEO C. PATTERSON</b>   |   | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |   | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |   | Address (Street, city, town or county)  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>REMOVAL</b>   | 23b. DATE THEREOF<br><b>1/30/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST. PAUL'S LUTHERAN</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>NORVELT PA</b>                                |
| 24. FUNERAL DIRECTOR<br><b>J.F. CONNELLY SONS</b>   |   | 25a. REC'D BY REGISTRAR<br><b>300 MACE</b> DATE <b>JAN 31 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

22. DATE SIGNED

**1/30/67**



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |  |  |  |  |  |   |  |  |  |
|--|--|----------------------------------|--|--|--|--|--|---|--|--|--|
| 00341  |  |                                  |  | CERTIFICATE OF DEATH   |  |  |  | 00344   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |  |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Balto.</u>                      |  |  |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>  |  |                                  |  | c. LENGTH OF STAY IN <u>13 DAYS</u>  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>  |  |                                  |  | d. STREET ADDRESS <u>67 Garden Ridge Rd.</u>   |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>KANNIE</u> Middle <u>HOWRY</u> Last <u>HOWRY</u>  |  |                                  |  | 4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1967</u>   |  |  |  |   |  |  |  |
| 5. SEX <u>F</u>  |  | 6. COLOR OR RACE <u>W</u>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>5/21/86</u>  |  | 9. AGE (In years last birthday) <u>80</u> yrs.  |  | IF UNDER 1 YEAR Months Days Hours Min.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N A</u>   |  |                                  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>X A</u>   |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. MD</u>                              |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>      |  |
| 13. FATHER'S NAME <u>Albert Miller</u>   |  |                                  |  | 14. MOTHER'S MAIDEN NAME <u>Brown</u>  |  |  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>  |  |                                  |  | 16. SOCIAL SECURITY NO. <u>713-10-0328</u>   |  |  |  | 17. INFORMANT <u>Patient's Chart</u> Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pulmonary Embolus leading to Cardiovascular Collapse</u><br>DUE TO (b) <u></u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |                                  |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>48h.</u> |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Gall Bladder with perforation</u>  |  |                                  |  |  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |                                  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-3-</u> , 19 <u>67</u> , to <u>1-16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> , 19 <u>67</u> , and that death occurred at <u>5:30 AM</u> from the causes and on the date stated above.   |  |                                  |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE <u>R K. CHILLAR</u>   |  |                                  |  | 22b. DATE SIGNED <u>1-16-67</u>  |  |  |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHILLAR</u>   |  |                                  |  | 22d. ADDRESS <u>4th. BALTIMORE MED. CENTER BALTIMORE, MD. 21204</u>  |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1-19-67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK Cem</u>  |  | 23d. LOCATION (City, town or county) (State) <u>Woodlawn MARYLAND</u>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson Inc</u>   |  |                                  |  | 25a. REC'D BY REGISTRAR <u>Towson, MD</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                        |  |   |  |  |  |



10-1  
10-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 4 from 3/24 4/12/67 mlh

00342

CERTIFICATE OF DEATH

00345

|  |                            |  |  |
|--|----------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>LUKOSZEWICZ, KONSTANTIN</b>  |                            | 2. DATE AND HOUR OF DEATH<br><b>4/2/67 4:30 P.M.</b>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>BALTIMORE COUNTY</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>CATON RIDGE NURSING HOME<br/>329 HARLEM LANE<br/>BALTIMORE MD 21229</b>   |                            | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE MD 21229</b><br>D. STREET ADDRESS (If rural, give location)<br><b>329 HARLEM LANE 822 1/2 W. Lombard St.</b> |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b>        | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>SINGLE</b>  | 8. DATE OF BIRTH<br><b>2-2-86</b>            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Paper Hanger</b>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self-Employed</b>  | 9. AGE (In years last birthday)<br><b>80</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>LITHUANIA</b>  |                            | 12. CITIZEN OF WHAT COUNTRY<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>ZANON LUKOSZEWICZ</b>  |                            | 14. MOTHER'S MAIDEN NAME<br><b>EVA PASKAVICH</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                            | 16. SOCIAL SECURITY NO.<br><b>?</b>  |  |
| 17. INFORMANT<br><b>CHART</b>  |                            | ADDRESS<br><b>Alone</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>154X</b>  |                            | CAUSE OF DEATH<br>(A) <b>Intermittent cardiac</b><br>DUE TO <b>cardiac disease</b><br>(B) <b>ADENOCARCINOMA OF</b><br>DUE TO <b>RECTUM</b><br>(C)  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                            | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 28</b> 19 <b>66</b> to <b>Jan 2</b> 19 <b>67</b> .<br>that (I) (we) last saw the deceased alive on <b>Dec 30</b> 19 <b>66</b> and that in (my) (our) opinion death occurred on the date<br>and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                            |  |  |
| 23A. SIGNATURE<br><b>E. Kasaitis M.D.</b>  |                            | 23B. DATE SIGNED<br><b>4/2/67</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>E. KASAITIS</b>   |                            | 23D. ADDRESS<br>M.D. <b>1801 FREDERICK RD #28</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 24B. DATE<br><b>4/2/67</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>St. Leonard's Cemetery</b>  | 24D. LOCATION<br><b>Not</b>                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 9 1967</b>   |                            | 25B. NAME OF SPECIAL AGENT<br><b>John F. Cavanaugh</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>John F. Cavanaugh Inc</b>  |                            | ADDRESS<br><b>Not</b>  |  |



00343

## CERTIFICATE OF DEATH

00346

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>RIVERIA BEACH</b>   |   |
| c. LENGTH OF STAY IN 1b<br><b>4 DAYS</b>  |   | d. STREET ADDRESS<br><b>258 KENWOOD ROAD</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>WILLIAM</b> Middle <b>JOSEPH</b> Last <b>LYNCH</b>  |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>28</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>SEPTEMBER 16, 1919</b>   |
| 9. AGE (In years last birthday)<br><b>47</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>        |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OFFICE WORKER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>CANADA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>JOSEPH LYNCH</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>AMADA PICARD</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>   |   | 16. SOCIAL SECURITY NO.<br><b>005 07 83 39</b>   |   |
| 17. INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS</b>  |   | <b>FORT HOWARD, MARYLAND</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LAENNEC'S CIRRHOSIS</b><br>DUE TO<br>(c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><br><b>YEARS</b>                               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>DELIRIUM TREMENS</b>  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <b>IV</b> (this hospital) attended the deceased from <b>JAN. 24</b> , 19 <b>67</b> , to <b>JAN. 28</b> , 19 <b>67</b> , that <b>IV</b> (we) last saw the deceased alive on <b>JAN. 28</b> , 19 <b>67</b> , and that death occurred at <b>1125A</b> M, from causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><i>Paulino D. Deocampo</i>  |   | 22b. DATE SIGNED<br><b>1-28-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>PAULINO D. DEOCAMPO, M.D.</b>  |   | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL (Cremation)</b>  | 23b. DATE THEREOF<br><b>1/31/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LORRAINE PARK CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>WOODLAWN, MARYLAND</b>                        |
| 24. FUNERAL DIRECTOR<br><b>LEONARD J. RUCK INC.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   | DATE<br><b>JAN 31 1967</b>   |   |
| 5305 HARFORD RD., BALTIMORE, MARYLAND   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (See page 1 and 2) Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| <div> <div> <div>1</div> <div>00344</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>CERTIFICATE OF DEATH</div> <div>00347</div> </div> </div>  |  |                               |                                  |  |  |   |  |  |  |                                  |  |
|--|--|-------------------------------|----------------------------------|--|--|---|--|--|--|----------------------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND<br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>c. LENGTH OF STAY IN 1b <u>2 Days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Med. Center</u>  |  |                               |                                  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21229</u><br>d. STREET ADDRESS <u>517 Allendale St.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                                  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>William May Mabon</u>  |  |                               |                                  | 4. DATE OF DEATH Month Day Year<br><u>1 / 14 / 1967</u>  |  |   |  |  |  |                                  |  |
| 5. SEX <u>Female</u>   |  | 6. COLOR OR RACE <u>White</u> |                                  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>6/4/18</u>  |  | 9. AGE (In years last birthday) <u>49</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |                                  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |  |                               |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |                                  |  |
| 13. FATHER'S NAME <u>John Thomas Laughlin</u>  |  |                               |                                  |  |  | 14. MOTHER'S MAIDEN NAME <u>Albie Lloyd</u>   |  |  |  |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>   |  |                               |                                  |  |  | 16. SOCIAL SECURITY NO. <u>[redacted]</u>   |  | 17. INFORMANT Address  |  |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>4:21<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO (b) <u>Arteriosclerotic vascular disease</u><br>DUE TO (c) <u>Dissecting aortic aneurysm</u> |  |                               |                                  |  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |                               |                                  |  |  |   |  |  |  |                                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                               |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |   |  |  |  |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |                               |                                  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 14, 1967</u> to <u>Jan. 14, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 14</u> 19. 67, and that death occurred at <u>6:30 P</u> M, from the causes and on the date stated above.  |  |                               |                                  |  |  |   |  |  |  |                                  |  |
| 22a. SIGNATURE <u>W. I. MacGregor</u>  |  |                               |                                  |  |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>   |  | 22b. DATE SIGNED <u>1-14-67</u>  |  |                                  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>W. I. MacGregor</u>  |  |                               |                                  |  |  | 22d. ADDRESS <u>Greater Baltimore Medical Center</u>  |  |  |  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |                               | 23b. DATE THEREOF <u>1-18-67</u> |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Louisa</u> |   |  | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>                                     |  |                                  |  |
| 24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson, Towson, Md.</u>  |  |                               |                                  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 19 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |  |                                  |  |



00345

## CERTIFICATE OF DEATH

00348

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and interment event, within 72 hours after death.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore Co.</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |   | c. LENGTH OF STAY IN lb. <u>8 yrs.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>              |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Aged Women's + Aged Men's Home</u>  |   | d. STREET ADDRESS <u>3114 Kentucky Ave</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Cora</u> Middle <u>E</u> Last <u>Maguire</u>   |   | 4. DATE OF DEATH<br>Month <u>JANUARY</u> Day <u>25</u> Year <u>1967</u>  |   |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>August 31, 1878</u> 93 yrs                           |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housekeeper</u>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Howard, Co.</u>  |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>William A. Maguire</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Edith Updegraff</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>218-52-2928</u>   |   |
| 17. INFORMANT<br><u>A.M. Weaver - Pickersgill</u>  |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>ASCVD</u><br>DUE TO (b) <u>ASCVD</u><br>DUE TO (c) |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 weeks</u>                          |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 25, 1959</u> , to <u>Jan. 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 25, 1967</u> , and that death occurred at <u>4 p.m.</u> from causes and on the date stated above.  |   |  |   |
| 22a. SIGNATURE<br><u>Newland E. Day</u>  |   | 22b. DATESIGNED<br><u>January 24, 1967</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Newland E. Day</u>  |   | 22d. ADDRESS<br><u>4-E-33rd St Balto. Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1-27-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Loudon Park Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>Wm. Cook-Brooks Towson Inc.</u>   |   | 25a. REC'D BY REGISTRAR<br><u>JAN 30 1967</u>  |   |
| ADDRESS<br><u>1050 York Rd.</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |   |

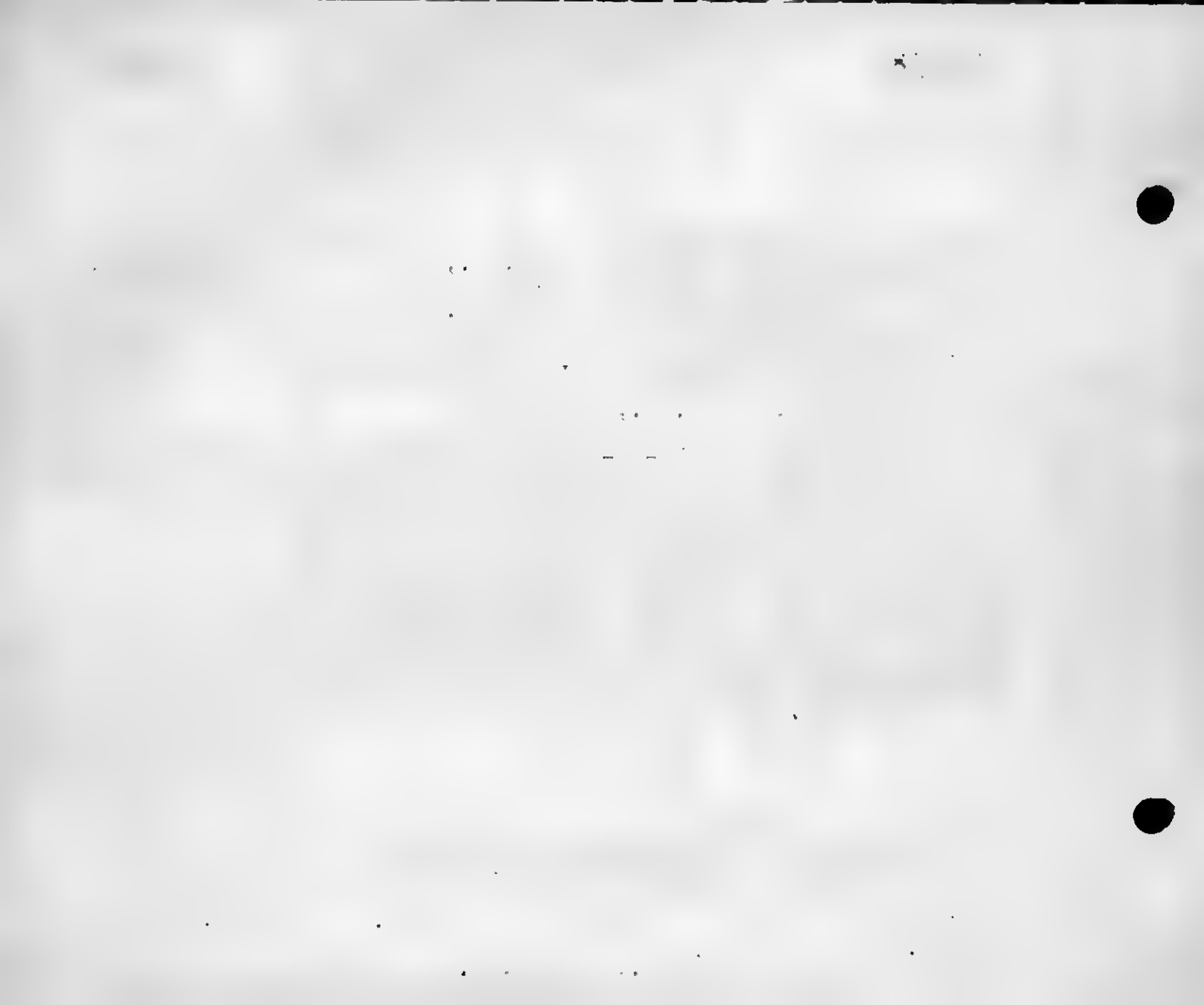


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                  |   |   |   |  |                                      |  |  |  |  |
|---|--|------------------|---|---|---|--|--------------------------------------|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                  |   |   |   |  |                                      |  |  |  |  |
| 00347   |  |                  |   |   | 00350   |  |                                      |  |  |  |  |
| 1. PLACE OF DEATH   |  |                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)       |  |                                      |  |  |  |  |
| a. COUNTY<br>Baltimore  |  |                  |   |   | a. STATE<br>Maryland  |  |                                      |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Dundalk   |  |                  |   |   | b. COUNTY<br>Baltimore  |  |                                      |  |  |  |  |
| c. LENGTH OF STAY IN ID<br>38 years   |  |                  |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br>Dundalk |  |                                      |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br>6915 Dunmanway  |  |                  |   |   | d. STREET ADDRESS<br>6915 Dunmanway   |  |                                      |  |  |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                  |   |   |   |  |                                      |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)   |  |                  | 4. DATE OF DEATH  |   |   | Month  |                                      |  | Day  |  |  |
| First Middle Last<br>MARTIN JOSEPH MALEY, Jr.,  |  |                  | January 28, 1967  |   |   |  |                                      |  |  |  |  |
| 5. SEX  |  | 6. COLOR OR RACE |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> |   | 8. DATE OF BIRTH   |                                      | 9. AGE (In years last birthday)                                      |  | IF UNDER 1 YEAR IF UNDER 24 HRS.   |  |
| male  |  | white            |   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                    |   | Aug. 16, 1910  |                                      | 56 yrs.  |  | Months Days Hours Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Die Maker  |  |                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br>Steel Mfr.                                       |   |  |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br>West Virginia |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |  |
| 13. FATHER'S NAME<br>Martin J. Maley, Sr.,  |  |                  |   |   |   | 14. MOTHER'S MAIDEN NAME<br>Kathryn Barrett  |                                      |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br>No   |  |                  |   | 16. SOCIAL SECURITY NO.<br>213-07-9197  |   | 17. INFORMANT<br>Dolores Maley, Same as #2   |                                      |  |  | Address  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Myocardial Infarction due to Coronary Artery Thrombosis<br>4201 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis<br>DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombosis, H. Middle cerebral artery |  |                  |   |   |   |  |                                      |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  |   |   |   |  |                                      |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m. 19  |  |                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                      |  | 20f. (City or town) (County) (State) |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 4, 1961, to Jan 28, 1967, that (I) (we) last saw the deceased alive on Jan 20, 1967, and that death occurred at 12:30 PM, from the causes and on the date stated above.   |  |                  |   |   |   |  |                                      |  |  |  |  |
| 22a. SIGNATURE<br>Paul G. Koukoulas   |  |                  |   |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                      |  | 22b. DATE SIGNED<br>1/30/67                          |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br>PAUL G. KOUKOULAS MD  |  |                  |   |   |   | 22d. ADDRESS<br>6511 O'Donnell Street  |                                      |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |  |                  | 23b. DATE THEREOF<br>2/1/67   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Cathedral Cmty.                                   |  |                                      | 23d. LOCATION (City, town or county) (State)<br>Baltimore, Maryland  |  |  |  |
| 24. FUNERAL DIRECTOR<br>Walter Brooks Bradley, Inc., Dundalk, Md.   |  |                  |   |   |   | 25a. REC'D BY REGISTRAR<br>DATE FEB 1 1967   |                                      |  | 25b. REGISTRAR'S SIGNATURE<br>Charles J. [Signature] |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Item #7 File 330-10-777 PC

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00346

#12

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00349

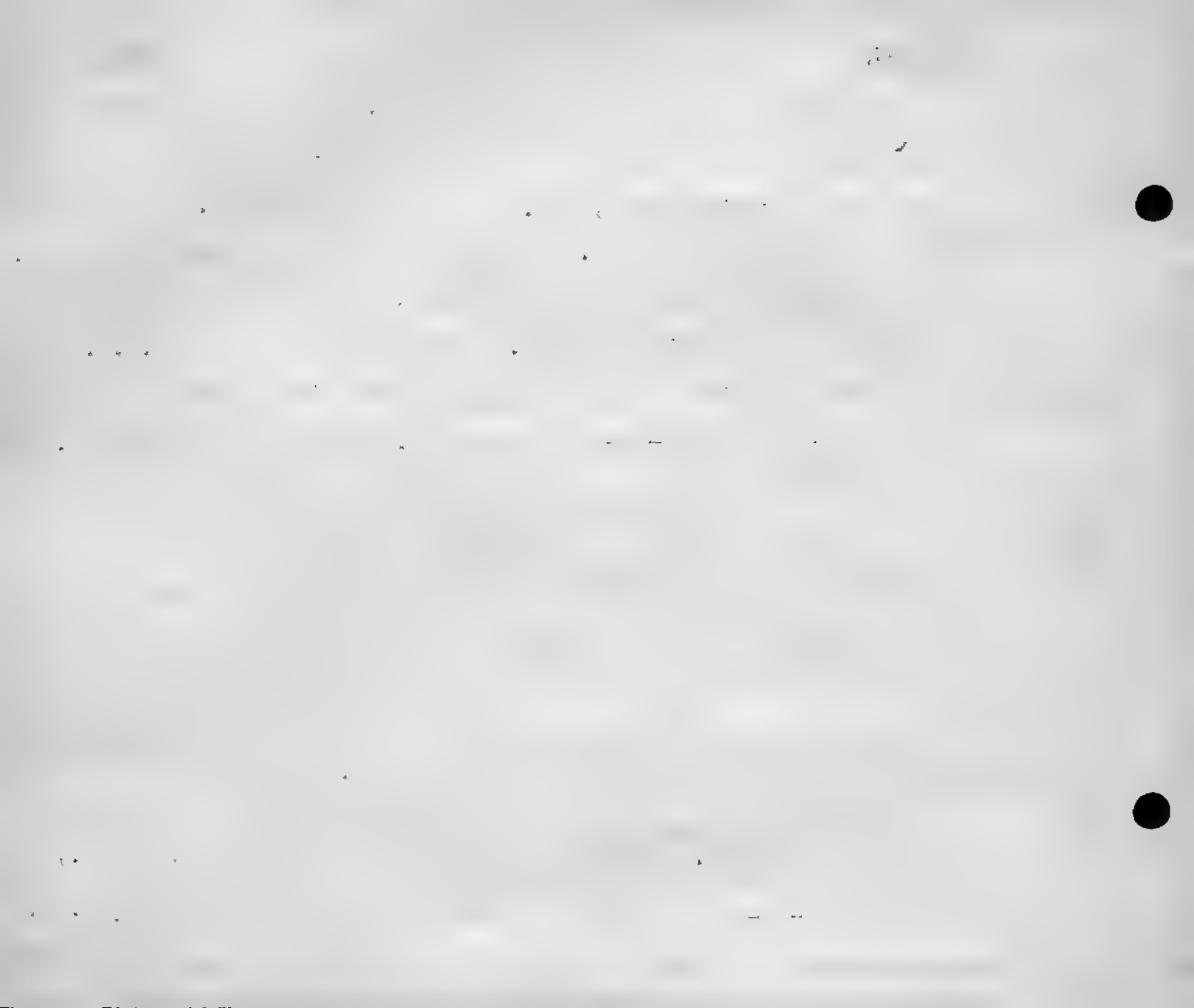
|   |                           |  |   |
|---|---------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Towson</b> <b>BALTIMORE</b><br>MARYLAND  |                           | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>TOWSON</b>   |                           | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                           | d. STREET ADDRESS<br><b>2807 Chesley Ave.</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Laura</b> Middle <b>Malinowski</b> Last <b>Malinowski</b>   |                           | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>8</b> Year <b>1967</b>   |   |
| 5. SEX <b>F</b>   | 6. COLOR OR RACE <b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Mar 22, 1888</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)<br><b>Housewife</b>  |                           | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>  |                           | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>Walter Swincinski</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>Felicia</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) [If yes give war or dates of service]<br><b>no</b>  |                           | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT<br><b>Family</b>  |                           | Address<br><b>Same</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>260X</b><br>IMMEDIATE CAUSE (a) <b>Primary Coronary Sudden</b><br>DUE TO (b) <b>Arteriosclerotic Cardiac Renal Vascular Disease</b><br>DUE TO (c) <b>Diabetes Mellitus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost  |                           | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b><br><b>10 yrs</b>   |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                           | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |                           | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18)   |   |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. p.m. <b>19</b>   |                           | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                           | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                           |  |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell, M.D.</b>   |                           | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |   |
| EXAMINER'S NAME (Type)<br><b>Charles F. O'Donnell, M.D.</b>   |                           | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |   |
|   |                           | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>   |   |
|   |                           | Address (Street, city, town, or county)  |   |
| 23a. BURIAL CREMATION, or other disposal (Specify)<br><b>Burial</b>   |                           | 23b. DATE THEREOF<br><b>11/2/67</b>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Cross</b>   |                           | 23d. LOCATION (City or Town) (County) (State)<br><b>AA Co Md</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>McCully F M 237 Patapsco Ave 21225</b>   |                           | 25. REC'D BY REGISTRAR<br>DATE <b>JAN 12 1967</b>  |   |
|   |                           | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |   |  |  |  |  |  |  |  |
| 00348  |  |  |  | CERTIFICATE OF DEATH  |  |  |  | 00351  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b><br>c. LENGTH OF STAY IN TB<br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Forest Haven Nursing Home, Inc.</b> |  |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Baltimore</b><br>d. STREET ADDRESS <b>7406 Belmont Ave. 315 Ingleside Ave.</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>HENRY F. MAROTZ</b>  |  |  |  | 4. DATE OF DEATH <b>January 20 1967</b>   |  |  |  | 9. AGE (in years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.   |  |  |  |
| 5. SEX <b>Male</b>   |  |  |  | 6. COLOR OR RACE <b>White</b>   |  |  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  |
| 8. DATE OF BIRTH <b>May 20, 1890</b>   |  |  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>Nelson Box Co. Baltimore, Md.</b>   |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |  |  | 13. FATHER'S NAME <b>Julius Marotz</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME <b>Sophia Maisenhalder</b>  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO. <b>212-09-2124 A-</b>  |  |  |  |
| 17. INFORMANT <b>Anna M. Ortel</b>   |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ANTHROPIC CAUSE - CATONIA</b><br>DUE TO <b>DISINFECTION &amp; MYOCHYMIA INFLAMMATION</b><br>DUE TO <b>FEVER &amp; ANTHROPIC CAUSE - CATONIA</b><br>DUE TO <b>SPINAL</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>  |  |  |  |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>   |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  | 20f. (City or town) (County) (State)   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>66</b> to <b>1/20</b> 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>1/10</b> 19 <b>67</b> and that death occurred at <b>11 PM</b> from the causes and on the date stated above.                       |  |  |  |   |  |  |  |  |  |  |  |
| 22a. SIGNATURE <b>John H. Shaw</b>   |  |  |  | 22b. DATE SIGNED <b>1/23/67</b>   |  |  |  | 22c. PHYSICIAN'S NAME (Type) <b>JOHN H. SHAW</b>   |  |  |  |
| 22d. ADDRESS <b>5800 Edmondson Ave. Balto., Md.</b>  |  |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  |  |  | 23b. DATE THEREOF <b>1-23-67</b>   |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>  |  |  |  | 23d. LOCATION (City, town or county) (State) <b>7225 Eastern Blvd. Ba. Co. Md.</b>  |  |  |  | 24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. Jailer</b>  |  |  |  |
| 24a. ADDRESS <b>6224 Eastern Ave. Baltimore, 21224, MD.</b>  |  |  |  | 24b. REC'D BY REGISTRAR <b>JAN 24 1967</b>  |  |  |  | 24c. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed and filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
00349 Item 6 1/17/67 mh 00352

|  |                               |   |   |
|--|-------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>4105 Essex Rd. Pikesville</u><br>c. LENGTH OF STAY IN 1b <u>4 yrs</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Katherine Robb Nursing Home</u>  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)<br>a. STATE <u>New Jersey</u> b. COUNTY <u>Gloucester</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pitman</u><br>d. STREET ADDRESS <u>216 Boulevard</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>McLarrick</u>   |                               | 4. DATE OF DEATH<br>Month <u>Jan</u> Day <u>10</u> Year <u>1967</u>   |   |
| 5. SEX <u>Female</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <u>April 14 1877</u> AGE (In years last birthday) <u>95</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>   |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Philadelphia Pa</u>   |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>  |   |
| 13. FATHER'S NAME <u>William Henderson</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Elizabeth Campbell</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                               | 16. SOCIAL SECURITY NO. <u>—</u>  |   |
| 17. INFORMANT <u>Anne Morgan Pikesville</u>  |                               | Address <u>4215 Melford Mill Rd. Baltimore Md 21207</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><u>450.0</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Arteriosclerosis, generalized.</u> |                               | INTERVAL BETWEEN ONSET AND DEATH <u>Several years</u>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOT BY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u> p.m.  |                               | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sep 17</u> ....., 19 <u>67</u> to <u>Jan 10</u> ...., 19 <u>67</u> , that (I) ( <u>no</u> ) last saw the deceased alive on... <u>Dec 19</u> 19 <u>66</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.  |                               |   |   |
| 22a. SIGNATURE <u>Paul H Royse</u>   |                               | 22b. DATE SIGNED  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>PAUL H ROYSE</u>   |                               | 22d. ADDRESS <u>1403 Foley La. Baltimore, Md. 21205</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                               | 23b. DATE THEREOF <u>1-13-67</u>  |   |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Moriah Cem.</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>Phila Pa.</u>   |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Howell Corp. Pikesville, Md.</u>  |                               | 25a. REC'D BY REGISTRAR <u>JAN 13 1967</u>  |   |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>  |                               |   |   |



00350

## CERTIFICATE OF DEATH

00353

|  |  |  |   |
|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b>          |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  | c. LENGTH OF STAY IN 1b<br><b>48 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>4809 ALTHEA AVENUE</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MATTHEW</b> Middle <b>L.</b> Last <b>MC CARTER</b>   |  | 4. DATE OF DEATH<br>Month <b>1/</b> Day <b>10</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/26/86</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>GENERAL ENGINEER</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) yrs. <b>80</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PENNSYLVANIA</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>MATTHEW MC CARTER</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH CLARK</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212 26 30 24</b>   |   |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><del>X</del> <b>CARCINOMA OF RECTUM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c) |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT &amp; OLD</b><br><b>UNKNOWN</b>                     |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>11/23/66</b> , 19__ to <b>1/10/67</b> , 19__, that <del>he</del> (we) last saw the deceased alive on <b>1/10/67</b> , 19__, and that death occurred at <b>6:45 AM</b> from causes and on the date stated above.                                   |  |  |   |
| 22a. SIGNATURE<br><i>George C. McElPatrick</i>   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          | 22b. DATE SIGNED<br><b>1/10/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE C. McELPATRICK, M. D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1/12/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDEN PARK NATIONAL</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. RUCK FUNERAL HOME</b><br><b>3305 HARTFORD ROAD, BALTIMORE, MD.</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00351

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00354

|   |  |  |  |
|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if not in residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>                              |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>LUTHERVILLE</b>  |  | c. LENGTH OF STAY N 1b<br><b>3 YRS.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>406 FOX CHAPEL DRIVE</b>   |  | d. STREET ADDRESS<br><b>406 FOX CHAPEL DRIVE</b>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>ROY EDWARD Mc DANIEL</b>  |  | 4 DATE OF DEATH<br>Month <b>JAN</b> Day <b>3</b> Year <b>1967</b>  |  |
| 5 SEX<br><b>M</b>   | 6 COLOR OR RACE<br><b>W</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>9-26-05</b>            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ASS. MANAGER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HUMBLE OIL &amp; REFINING CO.</b>  | 9 AGE (In years last birthday) yrs <b>61</b> |
| 11. FATHER'S NAME<br><b>HENRY GRANT Mc DANIEL</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. MOTHER'S MAIDEN NAME<br><b>SUDIE CLARK</b>  |  | 14. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>234-10-7486</b>   |  |
| 17. INFORMANT<br><b>Mrs. MARY E. Mc DANIEL</b>  |  | Address<br><b>406 FOX CHAPEL DR</b>  |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>420.1 MYOCARDIAL INFARCTION</b><br>IMMEDIATE CAUSE (a)<br>DUE TO<br>(b)<br>DUE TO<br>(c)  |  | INTERVA. BETWEEN ONSET AND DEATH   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)         |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |  |
| ACTUAL SIGNATURE<br><b>William A. Pillsbury</b> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| EXAMINER'S NAME (Type)<br><b>WILLIAM A. PILLSBURY</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 23b. DATE THEREOF<br><b>1/7/68</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENBRIER BURIAL PARK</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>HINTON, W. VA.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks-Townson</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 6 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  | 25c. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





00352

## CERTIFICATE OF DEATH

00355

|  |                                    |   |  |
|--|------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>           |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                    | c. LENGTH OF STAY IN TB<br><b>lyrllmth2ldys</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                    | e. STREET ADDRESS<br><b>7510 Wellesley Drive</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Charles</b> Middle <b>NIMROD</b> Last <b>McDevitt</b>  |                                    | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>3</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>white</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 30, 1888</b>                                     |
| 9. AGE (In years last birthday) <b>78</b> yrs  |                                    | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>3</b> Hours <b>15</b> Min.   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>accountant</b>   |                                    | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Ohio</b>   |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Charles A. McDevitt</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Flora Whalen</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                    | 16. SOCIAL SECURITY NO<br><b>705-05-4899</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                    | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>420.0</b> IMMEDIATE CAUSE (a) <b>Acute heart failure</b><br>DUE TO<br>(b) <b>Arteriosclerotic heart disease</b><br>DUE TO<br>(c)                      |                                    | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Infected ulcers of buttocks</b>  |                                    | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                    | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                    | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (a) (this hospital) attended the deceased from <b>Jan. 12, 1965</b> to <b>Jan. 3, 1967</b> that (a) (we) last saw the deceased alive on <b>Jan. 3, 1967</b> , and that death occurred at <b>2:55</b> M, from causes and on the date stated above. |                                    |   |  |
| 22a. SIGNATURE<br><b>Stella Wachslar</b>   |                                    | 22b. DATE SIGNED<br><b>1-3-67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>   |                                    | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   | 23b. DATE THEREOF<br><b>1/6/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MEMORIAL PARK</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>ST. PETERSBURG, FLA.</b> |
| 24. FUNERAL DIRECTOR<br><b>E. S. Mac Nabb</b>  |                                    | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 6 1967</b>   |  |
| 301 Frederick Rd<br>Balto. Md #28  |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. There please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
20M 1/65

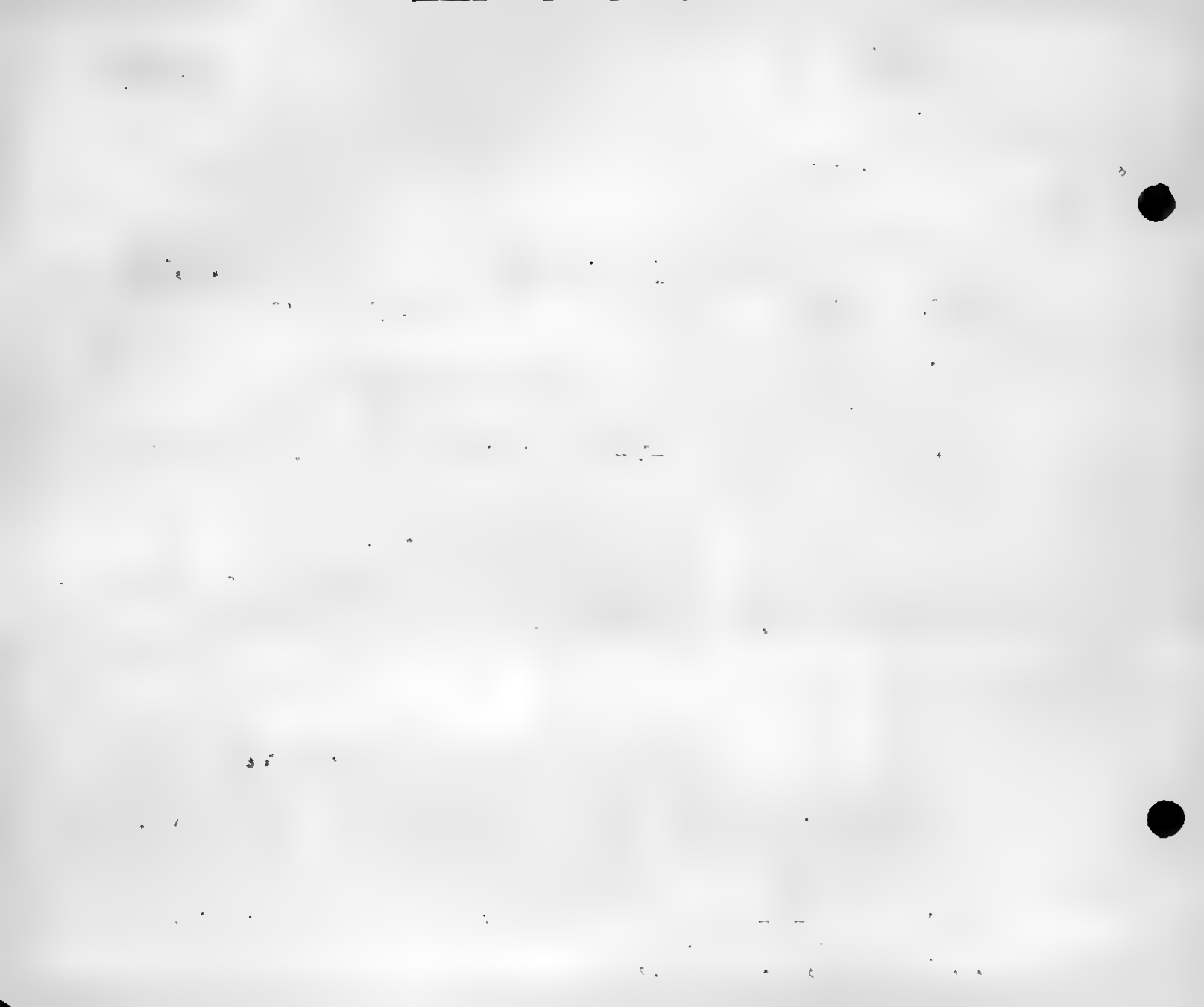
00353

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00356

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b>       |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Daniels</b>  |  |  |  | c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Guilford</b>   |  |  |  | d. STREET ADDRESS<br><b>Daniels</b>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>ELIZABETH SUSAN MC DONALD</b>  |  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>Jan. 25, 1967</b>  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 20, 1895</b>                                 |  |
| 9. AGE (In years last birthday)<br><b>71</b> yrs.   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At. Home</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>   |  |
| 13. FATHER'S NAME<br><b>Ezrael Funk</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Amanda Whitmore</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO.<br><b>215-12-1030</b>   |  | 17. INFORMANT<br><b>Louis Mc Donald, P.O. Box 124, Daniels, Md</b>       |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b><br>4330 DUE TO <b>CONGESTIVE HEART FAILURE</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(c) <b>CHRONIC PYELONEPHRITIS</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC PYELONEPHRITIS</b> |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                     |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>10-23</b> , 1957, to <b>1-28</b> , 1967, that (I) (we) last saw the deceased alive on <b>1-18</b> , 1967, and that death occurred at <b>M</b> , from the causes and on the date stated above.  |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>John V. Howard</b>   |  |  |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>1-26-67</b>                                       |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  |  | 22d. ADDRESS  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>1-28-1967</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Good Shepherd</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Ellicott City, Md</b> |  |
| 24. FUNERAL DIRECTOR<br><b>F.C. Higginbotham, Ellicott City, Md</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 27 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John Charles Judge</b>                  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

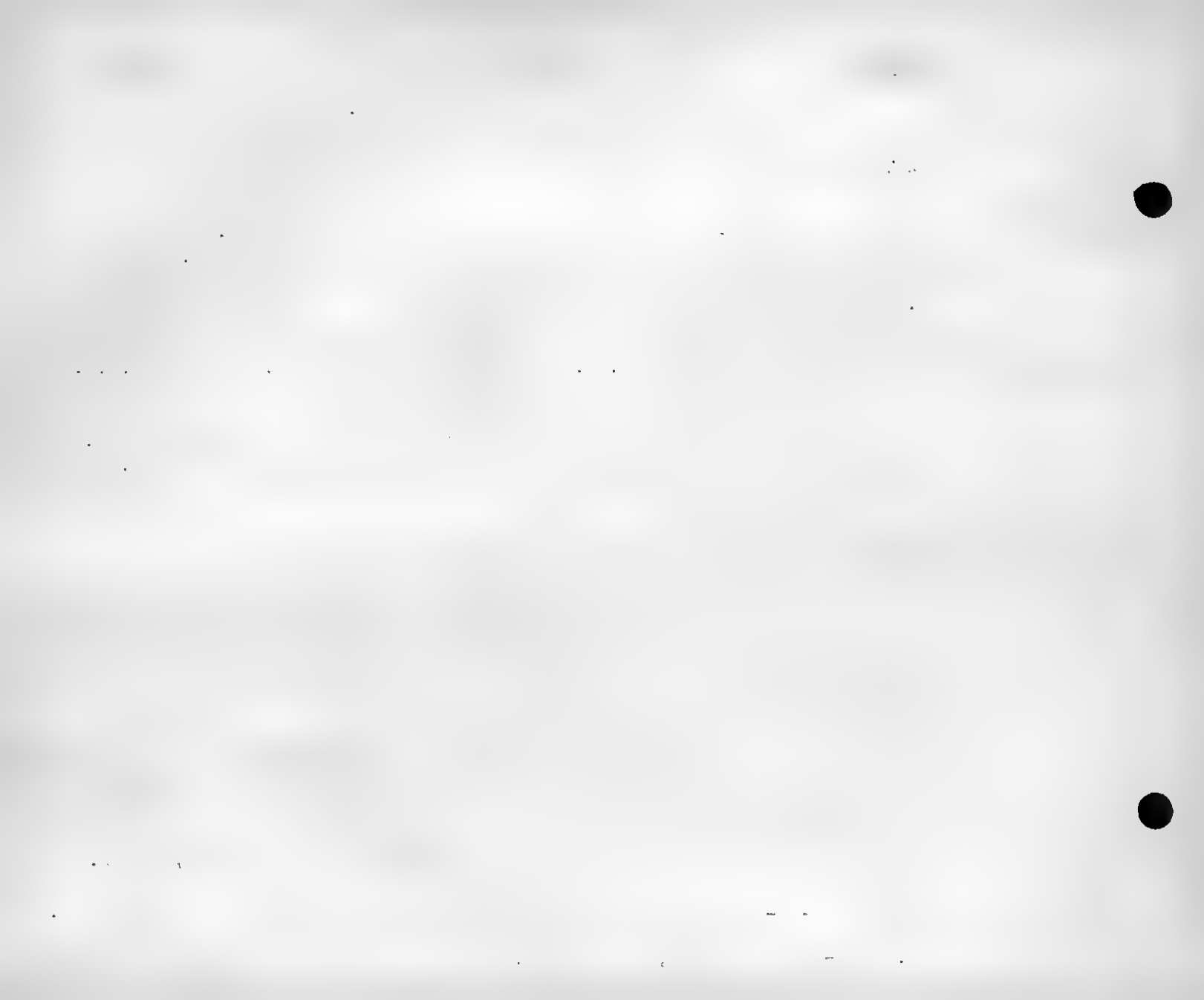
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00354

CERTIFICATE OF DEATH

00357


|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Md.</b><br>b. COUNTY <b>Baltimore</b>                   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   | c. LENGTH OF STAY in 1b<br><b>15 days</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Chesapeake Manor</b>  |   | d. STREET ADDRESS<br><b>904 Wellington Rd.</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Harold Paul McEntee</b>   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>19</b> Year <b>67</b>  |  |
| 5. SEX<br><b>M.</b>  | 6. COLOR OR RACE<br><b>Cauc</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>4-28-1897</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Auditing</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B&amp;O R.R.Co.</b>   | 9. AGE (In years lost 69 day) yrs<br><b>69</b>                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Covington, Ky.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>James McEntee</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Ida Mae Martin</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Unknown</b>  |   | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Dorothy McEntee, 904 Wellington Rd.</b>  |   | Address<br><b>Baltimore, Md. 21212</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>163X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of lung</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 years</b> |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. 19<br>p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>May 8</b> , 19 <b>67</b> to <b>1/19</b> , 19 <b>67</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/18</b> , 19 <b>67</b> , and that death occurred at <b>7:50 AM</b> , from causes on and on the date stated above.                                    |   |   |  |
| 22a. SIGNATURE<br><b>William Fr. Fritz</b>   |   | 22b. DATE SIGNED<br><b>1/20/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>William Fr. Fritz</b>  |   | 22d. ADDRESS<br><b>2 West University Pkwy, Balt 21218</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-23-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Woodlawn, Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson, Towson, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 24 1967</b>  |  |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
 Item #2c & d Film 6-3/27/57 pc  
**CERTIFICATE OF DEATH**

**00355**

**00358**

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <input checked="" type="checkbox"/><br>a. STATE <b>Maryland</b> b. COUNTY <b>Cecil Co.</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |   | c. LENGTH OF STAY IN 1b<br><b>2yrs8ms.5dys</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>E. New Market</b> <b>Elkton</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |  |   |  | d. STREET ADDRESS<br><b>265 Mackall St.</b><br><b>Springdale Nursing Home</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) First <b>ANNA</b> Middle <b>(McKinney)</b> Last <b>McKinney</b><br><b>Mollie (McKinney) McKenney</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>24</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                     |  | 8. DATE OF BIRTH<br><b>1992 10-7-1891</b>   |  |
| 9. AGE (In years last birthday)<br><b>75</b> yrs  |  | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>19</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ELK NECK, MD</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>ELK NECK, MD</b>                        |  |
| 13. FATHER'S NAME<br><b>CHARLES M. JONES</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET E. DAVIS</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-54-3233</b>   |  | 17. INFORMANT<br>Address <b>Records: Spring Grove State Hospital</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Peritonitis, generalized</b><br>570.3 DUE TO <b>volvulus</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>DUE TO (b) <b>megacolon and fecal impaction</b><br>(c) <b>megacolon and fecal impaction</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>2 days</b><br><b>1 month</b> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>5-19-64</b> , 19__ to <b>1-24-67</b> , 19__, that (s) (we) last saw the deceased alive on <b>1-24-67</b> , 19__, and that death occurred at <b>2:20 M.</b> from causes and on the date stated above.   |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br>   |  |   |  | 22b. DATE SIGNED<br><b>1-24-67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Anthony J. Young, M.D.</b>                                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  |   |  | 23b. DATE THEREOF<br><b>1-26-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>NORTH EAST METH.</b>                                     |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>NORTH EAST CECIL MD</b>   |  |   |  | 24. FUNERAL DIRECTOR<br><b>GRANT HOANG</b>  |  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  | 26. DATE<br><b>JAN 27 1967</b>  |  |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal to any event within 72 hours after death.

VR A15ME (5)  
GM 1/66

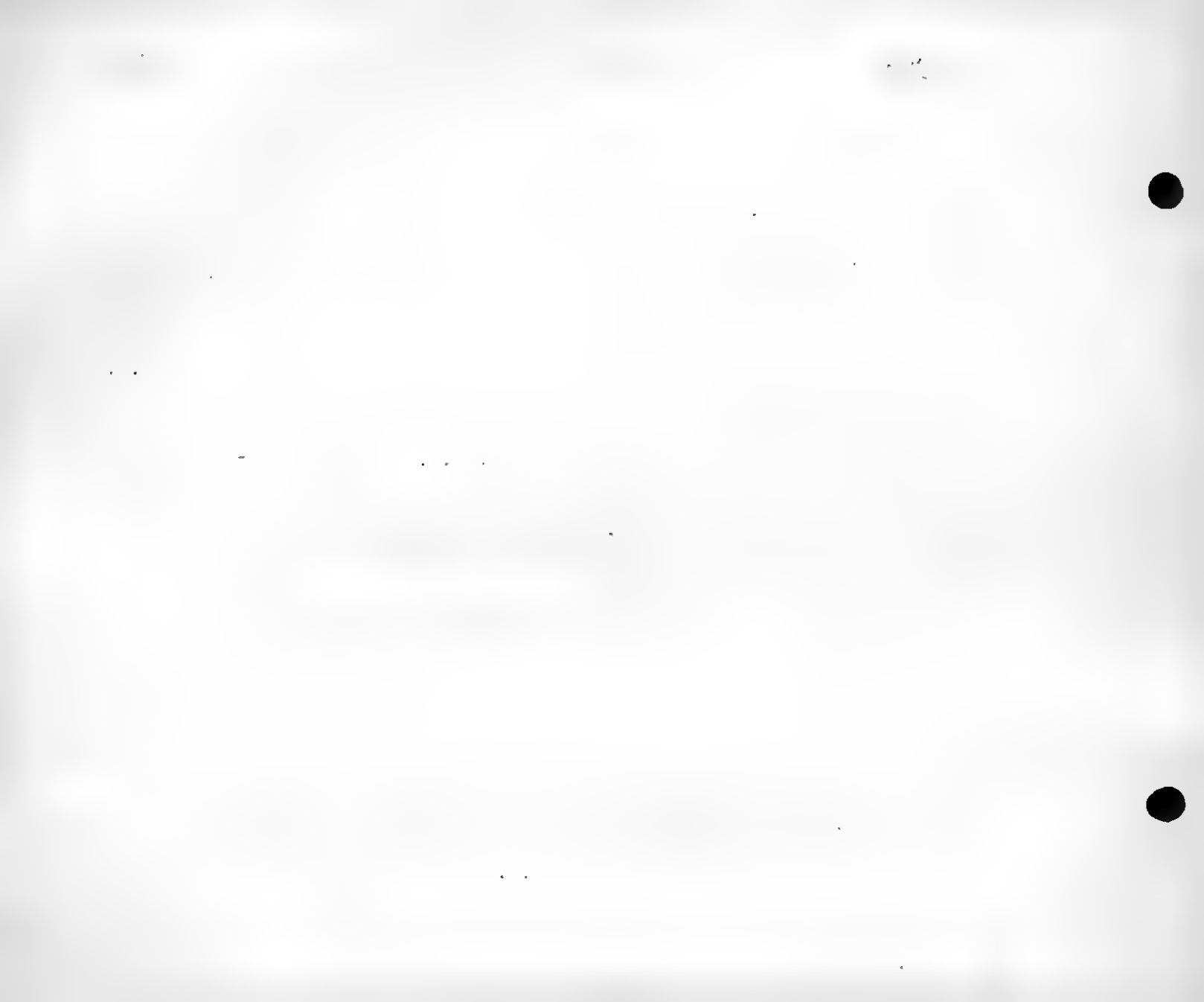
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00356

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00359

|   |                                  |   |  |
|---|----------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Chesaco Park</b>   |                                  | c. LENGTH OF STAY IN It<br><b>Chesaco Park</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>351 Potomac Avenue</b>   |                                  | d. STREET ADDRESS<br><b>351 Potomac Avenue</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>FREDERICK GUY McMILLEN</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 7, 1967</b>  |  |
| 5 SEX<br><b>Male</b>  | 6. COLOR OF RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>4-19-1889</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   | 9 AGE (In years birthday) yrs<br><b>77</b>   |
| 11 BIRTHPLACE (State or foreign country)<br><b>Kitzmiller, Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Elmer Elsworth McMillen</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Luella Milles</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>236-18-5227</b>  |  |
| 17. INFORMANT<br><b>Rev. C.W. Whalen, 351 Potomac Ave.</b>  |                                  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>4201 DUE TO <b>Hypertensive Cardiovascular Disease</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dissecting</b><br>(c) <b>Dissecting</b>  |                                  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                         |
| 20f. (City or town) (County) (State)  |                                  | 20g. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                  |   |  |
| ACTUAL SIGNATURE<br><b>Theodore C. Patterson</b> M.D.   |                                  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Dr. Theodore C. Patterson, M.D.</b>  |                                  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1-10-1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maplewood Cemetery</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Elkins, West Virginia</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 10 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                  | 22. DATE SIGNED<br><b>1/7/67</b>  |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00360

FOR STATE  
HEALTH DEPT.

00357

|  |   |  |  |
|--|---|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |   | c. LENGTH OF STAY in hb<br><b>30.4</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Shangrila Nursing Home</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>EMMA</b> Middle <b>L.</b> Last <b>MEEKS</b>   |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>14</b> Year <b>19 67</b>  |  |
| 5 SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>July 4, 1881</b>   |
| 9 AGE (In years last birthday)<br><b>85</b> yrs  |   | 10 FUNDING YEAR<br>Months <b>14</b> Days <b>19</b> Hours <b>67</b> Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12 CITIZEN OF WHAT COUNTRY?  |  |
| 13 FATHER'S NAME<br><b>Joseph Trader</b>   |   | 14 MOTHER'S MAIDEN NAME<br><b>Lucretia Margaret Harris</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16 SOCIAL SECURITY NO.<br><b>212-01-8333 D</b>   |  |
| 17 INFORMANT<br><b>Miss Janet L. Meeks</b>   |   | Address<br><b>same address</b>   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b><br>600.0<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Right Acute Pyelonephritis.</b><br>(c)  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| ACTUAL SIGNATURE<br><b>Charles S. Petty</b> M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |  |
| EXAMINER'S NAME (Type)<br><b>Charles S. Petty</b>  |   | 22. DATE SIGNED<br><b>1/15/67</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/17/1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                      |
| 24 FUNERAL DIRECTOR<br><b>Wm. J. Fubner &amp; Sons</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 17 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J. J.</b>  |   |  |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



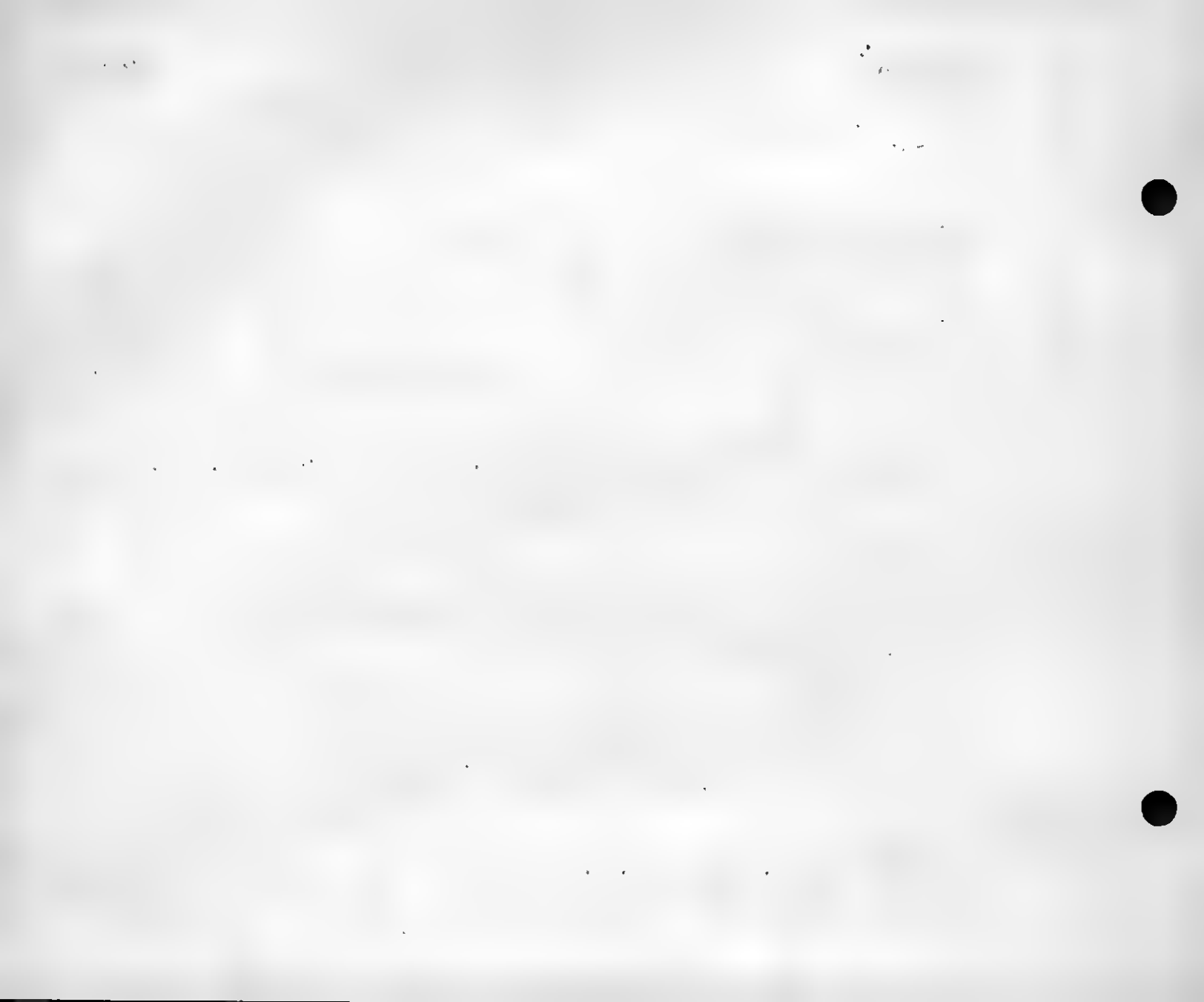
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
00358 Item 23b Film 6-85 2/6/67 mn CERTIFICATE OF DEATH 00361

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>                  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |   | c. LENGTH OF STAY IN TB<br><b>7 DAYS</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>ESSEX</b>  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>1621 RICKENBACKER ROAD</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3 NAME OF DECEASED<br>(Type or print) First <b>HARRY</b> Middle <b>JOHN</b> Last <b>MELL</b>  |   | 4 DATE OF DEATH Month <b>JANUARY</b> Day <b>29</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JUNE 14, 1891</b>  |
| 9. AGE (In years last birthday) <b>75</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months <b>11</b> Days <b>05</b> Hours <b>11</b> Min. <b>05</b>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CARPENTER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>FULTON COUNTY, PENNSYLVANIA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>WILLIAM MELL</b>  |   | 14. MOTHER'S MAIDEN NAME  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW-1</b>  |   | 16. SOCIAL SECURITY NO<br><b>213 07 5587</b>  |   |
| 17. INFORMANT<br><b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH |   |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>OBSTRUCTIVE EMPHYSEMA</b>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>JAN. 22</b> 19 <b>67</b> to <b>JAN. 29</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>JAN. 29</b> , 19 <b>67</b> , and that death occurred at <b>11:05 P.M.</b> from causes and on the date stated above.                  |   |   |   |
| 22a. SIGNATURE<br><i>John D. Talbert</i>  |   | 22b. DATE SIGNED<br><b>1 30 67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |   | 22d. ADDRESS<br><b>VET. ADM. HOSP., FT. HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>Feb. 1, 1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEMETERY</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Connelly Funeral Home</b><br><b>300 Mace Ave.</b><br><b>Baltimore 21, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 31 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |   |   |   |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00359

## CERTIFICATE OF DEATH

00362

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Parkville</b>  |  | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore #34</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>3108 DuBois Avenue</b>   |  | d. STREET ADDRESS<br><b>3108 DuBois Avenue</b>  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>EDITH</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 3, 1888.</b>  |
| 9. AGE (In years last birthday) yrs<br><b>78</b>  |  | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>19 67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of workable life, even if retired)<br><b>Housewife</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Joseph P. Sweglar</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Judith T. Murphy</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>216-01-0885B</b>  |  |
| 17. INFORMANT<br><b>Mr. Ernest L. Menefee,</b>  |  | Address<br><b>(Same)</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br><b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinomatous</b><br>DUE TO (b) <b>Carcinoma of Breast</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(c) |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>1/13</b> , 19 <b>67</b> that (I) (we) lost the deceased alive on <b>1/13</b> 19 <b>67</b> , and that death occurred at <b>2:55</b> M, from causes on and on the date stated above.  |  |   |  |
| 22a. SIGNATURE<br><b>Harold H. Burns M.D.</b>   |  | 22b. DATE SIGNED<br><b>1-16-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Harold H. Burns</b>  |  | 22d. ADDRESS<br><b>8106 Harford Rd.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Buried</b>  | 23b. DATE THEREOF<br><b>1/18/67.</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Moreland Memorial Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                                   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 18 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>[Signature]</b>   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00360

CERTIFICATE OF DEATH

00363

|  |                                  |   |                                      |
|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>                |                                      |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore Towson</u>  |                                  | c. LENGTH OF STAY IN 1b<br><u>9 days</u>  |                                      |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Greater Baltimore Medical Center</u>  |                                  | e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore 12</u>   |                                      |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elmer</u> Middle <u>BOND</u> Last <u>MERRITT</u>   |                                  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>26</u> Year <u>1967</u>   |                                      |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-24-1877</u> |
| 9. AGE (In years last birthday)<br><u>89</u> yrs.  |                                  | 10. IF UNDER 1 YEAR<br>Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>   |                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>House worker</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>OWN HOME</u>  |                                      |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore Co. Md</u>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                      |
| 13. FATHER'S NAME<br><u>Benjamin F. Bond</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Seamons</u>  |                                      |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>  </u>  |                                      |
| 17. INFORMANT<br><u>A. BOND MERRITT, 609 OVERBROOK Rd.</u>   |                                  | Address   |                                      |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Congestive heart failure. Pulmonary edema</u><br>(c) <u>  </u> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                      |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                  |   |                                      |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |                                      |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-17</u> , 19 <u>67</u> , to <u>1-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-26</u> , 19 <u>67</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.  |                                  |   |                                      |
| 22a. SIGNATURE<br><u>Juan L. Roque</u>   |                                  | 22b. DATE SIGNED<br><u>1/26/1967</u>  |                                      |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JUAN L. ROQUE</u>   |                                  | 22d. ADDRESS<br><u>6 BMC, Balto 4.</u>  |                                      |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THERE <u>1/30/1967</u>  |                                      |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Oak Lawn</u>  |                                  | 23d. LOCATION (City, town or county) (State)<br><u>Balto Co. Md.</u>  |                                      |
| 24. FUNERAL DIRECTOR<br><u>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. 12, Md.</u>  |                                  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>   |                                      |
| 25b. REGISTRAR'S SIGNATURE   |                                  | DATE <u>JAN 27 1967</u>   |                                      |

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CHICAGO, ILL. 60637

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UNIVERSITY OF CHICAGO

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00361

00364

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY _____                        |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>  |  |   |  | c. LENGTH OF STAY IN 1b<br><u>8 yrs.</u>   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Rosewood State Hospital</u>   |  |   |  | d. STREET ADDRESS<br><u>344 East 23 1/2 Street</u>   |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>Gordon</u> Middle <u>-</u> Last <u>MICKENS</u>  |  |   |  | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>19</u> Year <u>1967</u>  |  |   |  |
| 5. SEX<br><u>Male</u>  |  | 6. COLOR OR RACE<br><u>Negro</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>11/30/53</u>   |  |
| 9. AGE (In years last birthday)<br><u>13</u> yrs.  |  | IF UNDER 1 YEAR<br>Months _____ Days _____  |  | IF UNDER 24 HRS.<br>Hours _____ Min. _____   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Dependent</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Baltimore, Maryland</u>                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |  |   |  | 13. FATHER'S NAME<br><u>Charles Mickins</u>  |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><u>Catherine Logan</u>   |  |   |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>no</u>                                    |  |   |  |
| 16. SOCIAL SECURITY NO.<br><u>---</u>  |  |   |  | 17. INFORMANT<br>Address <u>Rosewood Records, Owings Mills, Maryland</u>   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Anoxia</u><br>DUE TO (b) <u>Terminal Myoclonic Seizure</u><br>DUE TO (c) <u>Multiple Congenital Abnormalities of Brain 4 yr</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____<br>INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u><br><u>Terminal</u> |  |   |  |  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 23, 1958</u> , to <u>last 18, 1967</u> , that (I) (we) last saw the deceased alive on <u>last 17, 1967</u> , and that death occurred at <u>2:20 P.M.</u> from the causes and on the date stated above.  |  |   |  |  |  |   |  |
| 22a. SIGNATURE<br><u>Harvey M. Solomon</u> M.D.  |  |   |  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>                          |  | 22b. DATE SIGNED<br><u>4/19/67</u>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Harvey M. Solomon, M.D.</u>   |  |   |  | 22d. ADDRESS<br><u>ROSEWOOD STATE HOSPITAL</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>1/25/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Rosewood Cemetery</u>   |  | 23d. LOCATION (City, town or county) (State)<br><u>Owings Mills, Md.</u>                          |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>J. F. Eline &amp; Sons</u>  |  |   |  | ADDRESS<br><u>Reisterstown, Md.</u>  |  | 25a. REC'D BY REGISTRAR<br><u>JAN 30 1967</u>   |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

00362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00365

|  |                                    |  |   |
|--|------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>1 hour</b>   |                                    | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b> |   |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>EDWARD J. MILLER JR.</b>   |                                    | 4 DATE OF DEATH<br>Month <b>Jan.</b> Day <b>10</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>    | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH<br><b>June 20, 1897</b>                                       |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Advertising Sales Mgr.</b>  |                                    | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Newspaper Advertising</b>   | 11 BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>             |
| 13 FATHER'S NAME<br><b>Edward J. Miller Sr.</b>  |                                    | 14 MOTHER'S MAIDEN NAME<br><b>Marion (not known)</b>   |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW-1</b>   |                                    | 16 SOCIAL SECURITY NO<br><b>WW-1</b>   |   |
| 17 INFORMANT<br><b>Edw. J. Miller 111</b>  |                                    | Address<br><b>204 Bradenwood Court<br/>Lutherville, Md. 21093</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Acute Respiratory Failure</b><br>DUE TO <b>Overdose of Librium</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>and Alcohol</b><br>DUE TO (c) <b>Sudden</b>   |                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>                             |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH: BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                    |  |   |
| 20a EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.   |                                    | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                    | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)         |
| 20f (City or town)   |                                    | (County) (State)   |   |
| 21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> |                                    |  |   |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b>  |                                    | 22. DATE SIGNED<br><b>1/10/67</b>  |   |
| EXAMINER'S NAME (Type)<br><b>CHARLES F. O'DONNELL, M.D.</b>  |                                    | Address (Street, city, town, or county)  |   |
| 23a BURIAL CREMATION<br>REMOVAL (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>1-13-67</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Maryland</b> |
| 24 FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson</b>   |                                    | Address<br><b>1050 York Road<br/>Towson, Maryland 21204</b>  | 25a REC'D BY REG-STRAR<br><b>JAN 13 1967</b>                                  |
|  |                                    | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove all papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00363

00366

|   |                                 |   |                                       |
|---|---------------------------------|---|---------------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTO.</b> MARYLAND  |                                 | 2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)<br>a. STATE <b>MO.</b> b. COUNTY <b>BALTO.</b>                          |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>  |                                 | c. LENGTH OF STAY IN 1b   |                                       |
| d. NAME OF HOSPITAL (If not in hospital, give street address)<br>OR INSTITUTION<br><b>SUMMIT NURSING HOME</b>   |                                 | d. STREET ADDRESS<br><b>5218 Gwynndale Ave</b>  |                                       |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><b>MARY E. MILLER</b>  |                                 | 4. DATE OF DEATH<br>Month Day Year<br><b>JAN. 4 1967</b>  |                                       |
| 5 SEX<br><b>FEMALE</b>  | 6 COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>MAY 2, 1877</b> |
| 9. AGE (in years last birthday) yrs<br><b>89</b>  |                                 | IF UNDER 1 YEAR IF UNDER 24 HRS<br>Months Days Hours Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSE WIFE</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>  |                                       |
| 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>  |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                                       |
| 13. FATHER'S NAME<br><b>ERASTES FOGG</b>  |                                 | 14. MOTHER'S MAIDEN NAME<br><b>RACHEL FOGG</b>  |                                       |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?<br>(Yes, no, or unknown) <b>NO</b>   |                                 | 16. SOCIAL SECURITY NO<br><b>217-54-8108</b>  |                                       |
| 17. INFORMANT<br>Address<br><b>Mrs. Eva E. OLIVERIO</b>   |                                 | <b>SAME AS 2-d</b>  |                                       |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  |                                 |   |                                       |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic Brain Syndrome Associated with Cerebral Arteriosclerosis.</b>  |                                 |   |                                       |
| DUE TO (b) <b>Arteriosclerotic Cardio Vascular Disease.</b>   |                                 |   |                                       |
| DUE TO (c) <b>Dissecting.</b>   |                                 |   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(3) Generalized Arteriosclerosis</b>   |                                 |   |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a m p. m. 19   |                                 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>                                     |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                 | 20f. (City or town) (County) (State)  |                                       |
| 21 I certify that (I) (this hospital) attended the deceased from <b>8/9/66</b> to <b>1/4/67</b> , that (I) <del>met</del> last saw the deceased alive on <b>1/3/67</b> , and that death occurred <b>2:45 AM</b> , from the causes and on the date stated above. |                                 |   |                                       |
| 22a. SIGNATURE<br><b>W E Mc Grath</b>   |                                 | 22b. DATE SIGNED<br><b>1/4/67</b>   |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><b>W E Mc Grath</b>   |                                 | 22d. ADDRESS<br><b>1303 Frederick Rd Catonsville MD.</b>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                 | 23b. DATE THEREOF<br><b>Jan. 6, 1967</b>  |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>LOUDON PARK</b>  |                                 | 23d. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>  |                                       |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>John T. Stunsbury Sr.</b>  |                                 | 25a. REC'D BY REGISTRAR<br><b>JAN 6 1967</b>  |                                       |
| ADDRESS<br><b>6411 Windsor Mill Rd.</b>   |                                 | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                       |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00364

CERTIFICATE OF DEATH

00367

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>61 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |  | d. STREET ADDRESS<br><b>2664 FLORA STREET</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>FRANCIS W MILLS</b>  |  | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 8 1967</b>   |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>NEGRO</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8-9-24</b>   |
| 9. AGE (In years last birthday)<br><b>42</b> yrs.   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PORTER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>GEORGE MILLS</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Luvenia Davis</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>  |  | 16. SOCIAL SECURITY NO<br><b>217 12 81 70</b>   |   |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH. FT. HOWARD, MARYLAND</b>   |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>150X CARCINOMA OF ESOPHAGUS WITH INVASION OF MEDIASTINUM</b><br>IMMEDIATE CAUSE (a) DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c) |  |   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (this hospital) attended the deceased from <b>11/3/66</b> , 19 to <b>1/8/67</b> , 19, that (we) last saw the deceased alive on <b>1/8/67</b> , 19, and that death occurred at <b>6:45 PM</b> , from causes and on the date stated above.   |  |   |   |
| 22a. SIGNATURE<br><i>Milton Ginsberg</i>  |  | 22b. DATE SIGNED<br><b>1/9/67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MILTON GINSBERG, M. D.</b>   |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1-12-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b> |
| 24. FUNERAL DIRECTOR<br><b>MARSHALL JONES</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 10 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |   |   |

11

10-0-8

• • •

00365

## CERTIFICATE OF DEATH

00368

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>MARYLAND</b> b COUNTY         |  |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |   | c. LENGTH OF STAY IN 1b<br><b>1 DAY</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   |   | d STREET ADDRESS<br><b>909 S. CHARLES STREET</b>  |  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |
| 3. NAME OF DECEASED (Type at print)<br>First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>MITCHELL</b>  |   |   | 4. DATE OF DEATH <b>JANUARY 10 19 67</b>  |  |   |
| 5. SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>DECEMBER 5, 1914</b>  | 9 AGE (In years)<br><b>52</b> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PAINTER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>CONTRACTING</b>   |   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>SHEPHERDSTOWN, W. VA.</b>                   |   |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |   | 13 FATHER'S NAME<br><b>WILL MITCHELL</b>  |  |   |
| 14 MOTHER'S MAIDEN NAME<br><b>LAURA SHANNON</b>   |   |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>      |  |   |
| 16 SOCIAL SECURITY NO.<br><b>232 26 74 80</b>   |   |   | 17 INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>   |  |   |
| 18 CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INFARCTION OF MYOCARDIUM</b><br>DUE TO <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO<br>(c) |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |   |  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that (h) (this hospital) attended the deceased from <b>JAN 9</b> , 19 <b>67</b> , to <b>JAN 10</b> , 1967, that (h) (we) last saw the deceased alive on <b>JAN 10</b> , 19 <b>67</b> , and that death occurred at <b>1000</b> A.M. from causes and on the date stated above.  |   |   |   |  |   |
| 22a. SIGNATURE<br><b>J. D. Talbert M.D.</b>   |   |   | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/10/67</b>  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>   |   |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1-13-67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                          |   |
| 24 FUNERAL DIRECTOR<br><b>ZANNINO FUNERAL HOME</b>  |   | 25a. REC'D BY REGISTRAR<br><b>DATE JAN 11 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                      |  |  |  |  |  |  |  |  |  |
|--|--|--------------------------------------|--|--|--|--|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                      |  |  |  |  |  |  |  |  |  |
| CERTIFICATE OF DEATH   |  |                                      |  |  |  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |                                      |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |  |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |  |                                      |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk 21222</b>                                     |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>7433 School Avenue</b>  |  |                                      |  |  |  | d. STREET ADDRESS<br><b>7433 School Avenue</b>   |  |  |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>HOMER</b> Middle <b>ANDERSON</b> Last <b>MOORE</b>   |  |                                      |  |  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>1967</b>  |  |  |  |  |  |
| 5. SEX<br><b>male</b>  |  | 6. COLOR OR RACE<br><b>white</b>     |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>June 9, 1915</b>  |  | 9. AGE (In years last birthday)<br><b>51</b> yrs.                          |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>10</b> Hours <b>15</b> Min. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Foreman</b>  |  |                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Steel</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |  |
| 13. FATHER'S NAME<br><b>Joel J. Moore</b>  |  |                                      |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Hitchcock</b>   |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>yes</b>  |  |                                      |  | 16. SOCIAL SECURITY NO.<br><b>215-07-2148</b>  |  | 17. INFORMANT<br>Address<br><b>Helen Pasek Moore, same as #2</b>   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA (PRIMARY UNCERTAIN)</b><br>DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____<br>DUE TO (c) _____ |  |                                      |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 mos.</b>                          |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |                                      |  |  |  |  |  |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                                      |  |  |  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  |                                      |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  |                                      |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                       |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>11-9</b> , 1966, to <b>1-31</b> , 1967, that (I) (we) last saw the deceased alive on <b>1-25</b> 1967, and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above.   |  |                                      |  |  |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>Carlton L. Sexton</b> M.D.  |  |                                      |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>              |  | 22b. DATE SIGNED<br><b>2/1/67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Carlton L. Sexton, MD.</b>  |  |                                      |  |  |  | 22d. ADDRESS<br><b>819 Park Avenue, Baltimore, Md.</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>2/3/1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>  |  |  |  | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b> |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Walter Brooks Bradley, Inc.</b> ADDRESS<br><b>Dundalk, Md.</b>  |  |                                      |  |  |  | 25a. REC'D BY REGISTRAR<br><b>FEB 3 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                         |  |  |  |



00367

## CERTIFICATE OF DEATH

00370

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>              |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   | c LENGTH OF STAY IN 1b<br><b>5 mths.</b>   | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Cockeysville</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Armacost Nursing Home</b>   |  | d STREET ADDRESS<br><b>Holly Hill Farm</b><br><b>21030</b>   | e IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>MARY</b><br>First Middle Last  |  | 4 DATE OF DEATH<br>Month Day Year<br><b>January 17 1967</b>  |  |
| 5 SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 2, 1884</b>   |
| 9 AGE (In years last birthday)<br><b>82</b> yrs.   |  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>George Goebel</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Hotz</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16 SOCIAL SECURITY NO<br><b>219-12-6874</b>  |  |
| 17 INFORMANT<br><b>Armacost Nursing Home</b>   |  | Address<br><b>Regester Ave.</b>  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b><br><b>4xviii</b> DUE TO <b>A.S.C.V. DISEASE.</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>3 DAYS</b><br><b>10 YRS. +</b> |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>DIABETES MELLITUS</b>   |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour am pm<br><b>19</b>   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 17, 1966</b> to <b>JAN. 17, 1967</b> , that (I) (we) last saw the deceased alive on <b>JAN. 17, 1967</b> , and that death occurred at <b>9:30 AM</b> , from causes and on the date stated above.  |  |  |  |
| 22a SIGNATURE<br><b>Arthur Karfegin</b>  |  | 22b. DATE SIGNED<br><b>1/18/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Arthur Karfegin</b>   |  | 22d. ADDRESS<br><b>1532 HAVENWOOD RD.</b><br><b>Northwood Shopping Center</b>  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b DATE THEREOF<br><b>1-17-67</b>   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore Maryland</b>                       |
| 24 FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson Inc.</b>  |  | 25a REC'D BY REGISTRAR<br><b>JAN 24 1967</b>   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





1  
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| MARYLAND DEPARTMENT OF HEALTH   |  |   |  |  |   |  |  |  |  |
|---|--|---|--|--|---|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |  |   |  |  |  |  |
| 00368   |  |   |  |  | 00371   |  |  |  |  |
| 1. PLACE OF DEATH   |  |   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)   |  |  |  |  |
| a. COUNTY   |  | Baltimore                               |  |  | a. STATE  |  | Md   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | Towson                                  |  |  | b. COUNTY   |  | Baltimore  |  |  |
| c. LENGTH OF STAY IN  |  | 7yrs                                    |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |  | Towson   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |  | Stella Maris Hospice                    |  |  | d. STREET ADDRESS   |  | 714 Stevenson Lane   |  |  |
| 3. NAME OF DECEASED (Type or print)   |  | Anna M. Morris                          |  |  | 4. DATE OF DEATH  |  | 1/28/67  |  |  |
| 5. SEX  |  | F                                       |  |  | 6. DATE OF BIRTH  |  | 19   |  |  |
| 6. COLOR OR RACE  |  | W                                       |  |  | 7. MARRIED  |  | NEVER MARRIED  |  |  |
| 7. MARRIED  |  | WIDOWED                                 |  |  | 8. DATE OF BIRTH  |  | 7/25/1877  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                       |  | HSWF                                    |  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | Baltimore, Md  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country)   |  | Baltimore, Md                           |  |  | 12. CITIZEN OF WHAT COUNTRY?  |  | USA  |  |  |
| 13. FATHER'S NAME   |  | Nicholas Cornelius Ganster              |  |  | 14. MOTHER'S MAIDEN NAME  |  | Sarah Bullard  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)                         |  | N                                       |  |  | 16. SOCIAL SECURITY NO.   |  | 216-09-5443  |  |  |
| 17. INFORMANT   |  | Hospice Records                         |  |  | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  | Interval BETWEEN ONSET AND DEATH   |  |  |
| PART I. DEATH WAS CAUSED BY:  |  | Arteriosclerotic Cardiovascular Disease |  |  | 19. WAS AUTOPSY PERFORMED?  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                          |  |  |
| IMMEDIATE CAUSE (a)   |  | 4221                                    |  |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |  |
| CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.                                    |  | DUE TO                                  |  |  | 20c. TIME OF INJURY   |  | 20d. INJURY OCCURRED   |  |  |
|   |  | DUE TO                                  |  |  | Hour a.m. 19  |  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>            |  |  |
|   |  | DUE TO                                  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |  |   |  |  | 21. I certify that (I) (this hospital) attended the deceased from May 8, 1959, to Jan. 28, 1967, that (I) (we) last saw the deceased alive on 1/26/67, and that death occurred at 5:10 PM from the causes and on the date stated above. |  | 22a. SIGNATURE   |  |  |
|   |  |   |  |  | 22c. PHYSICIAN'S NAME (Type)  |  | 22b. DATE SIGNED   |  |  |
|   |  | Frank Keuhn, M.D.                       |  |  | 22d. ADDRESS  |  | 1/2/8/67   |  |  |
|   |  | Medical Arts Bldg. Baltimore            |  |  | 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  | 23b. DATE THEREOF  |  |  |
|   |  | Burial                                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town or county) (State)   |  |  |
|   |  | 1/31/67                                 |  |  | Holy Redeemer Cemetery  |  | Baltimore, Maryland  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE  |  | Wm. Cook-Brooks                         |  |  | 25a. REC'D BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |
| Towson 1050 York Rd. 21204  |  | DATE FEB 1 1967                         |  |  | Charles Judge   |  |  |  |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

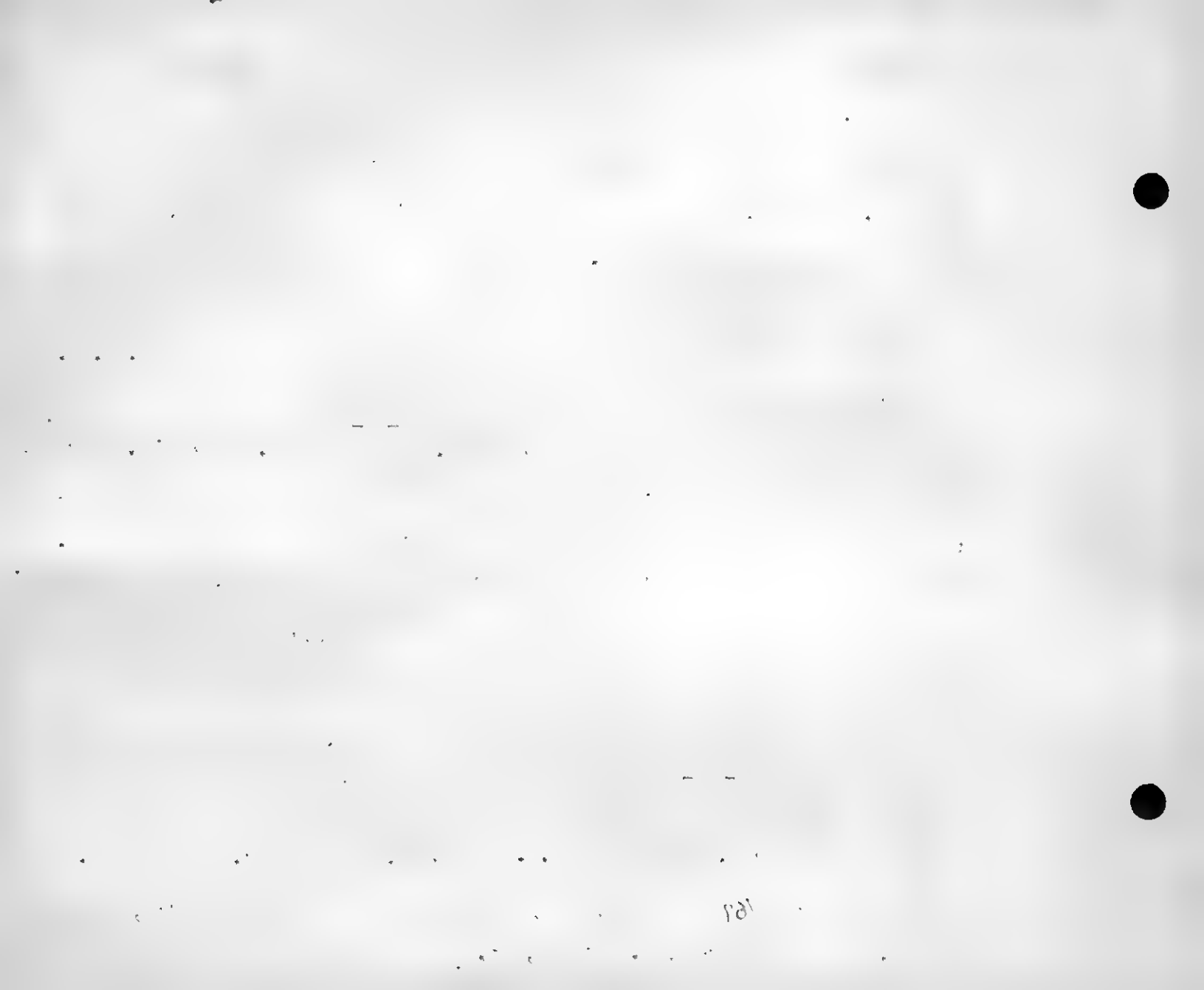
00363

## CERTIFICATE OF DEATH

00372

|  |  |   |  |   |  |   |   |
|--|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Virginia</b> b. COUNTY <b>Green</b>                    |  |   |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>2 Weeks</b>   |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>7915 St. Monica Drive</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lizzie</b> Middle <b>E.</b> Last <b>Morris</b>   |  |   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>26</b> Year <b>1967</b>   |  |   |   |
| 5. SEX<br><b>Female</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/26/93</b>   |   |
| 9. AGE (in years last birthday)<br><b>73</b> yrs.  |  | 10. IF UNDER 1 YEAR<br>Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.                               |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                               |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |   |   |
| 13. FATHER'S NAME<br><b>William Morris</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nellie Turner</b>  |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |  | 17. INFORMANT (Son-in-law)<br><b>James M. Woody</b>   |  | Address <b>Maryland</b><br><b>7915 St. Monica Dr. Dundalk,</b>                |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Uremic Coma</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Pyelonephritis</b><br>DUE TO<br>(c) <b>Diabetes Mellitis</b> |  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b><br><b>1 yr.</b><br><b>3 years</b>               |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Pneumonia</b>   |  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |   |  |   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>November, 1963</b> to <b>Jan 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-25-1967</b> , and that death occurred at <b>6:30 AM</b> , from the causes and on the date stated above.   |  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><i>Charles E. Thompson</i> M.D.  |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                             |  | 22b. DATE SIGNED<br><b>1/26/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Charles E. Thompson M.D.</b>  |  |   |  | 22d. ADDRESS<br><b>2903 W. Woodwell Rd. Dundalk, Md.</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>1/29/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ruckersville Cemetery</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>Ruckersville, Virginia</b> |   |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 27 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                            |   |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |
|--|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|
| 00370  |  |   |  |  |  | 00373  |  |   |  |  |  |  |  |   |  |
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5172 Viaduct Avenue</u>  |  |   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Relay</u><br>d. STREET ADDRESS <u>5172 Viaduct Avenue</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |  |  |  |  |   |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br>First <u>Daisy</u> Middle <u>S.</u> Last <u>Moszner</u>  |  |   |  |  |  | <b>4. DATE OF DEATH</b><br>Month <u>January</u> Day <u>27</u> Year <u>1967</u>   |  |   |  |  |  |  |  |   |  |
| <b>5. SEX</b><br><u>Female</u>   |  | <b>6. COLOR OR RACE</b><br><u>White</u> |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8. DATE OF BIRTH</b><br><u>February 25, 1877</u>  |  | <b>9. AGE</b> (In years last birthday) <u>89</u> yrs.                         |  | <b>IF UNDER 1 YEAR</b><br>Months <u>  </u> Days <u>  </u>            |  | <b>IF UNDER 24 HRS.</b><br>Hours <u>  </u> Min. <u>  </u>  |  |   |  |
| <b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>  </u>  |  |  |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>Maryland</u> |  |  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>  </u>   |  |   |  |
| <b>13. FATHER'S NAME</b><br><u>John L. Kenode</u>  |  |   |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Virginia C. Warner Brown</u>   |  |   |  |  |  |  |  |   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> None   |  |   |  |  |  | <b>16. SOCIAL SECURITY NO.</b> <u>  </u>   |  |   |  |  |  | <b>17. INFORMANT</b><br><u>Mr. Warner Brown</u>  |  | <b>Address</b><br><u>670 Turduck Road</u> |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>cardio-vascular disease</u><br>4x2x1 } DUE TO (b) <u>arteriosclerosis of aorta</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>  </u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> |  |   |  |  |  |  |  |   |  |  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>2 1/2 yrs</u>  |  |   |  |
| <b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |  |  |  |  |   |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18) |  |   |  |
| <b>20c. TIME OF INJURY</b><br>Month, Day, Year <u>19</u><br>Hour a.m. <u>  </u> p.m. <u>  </u>   |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>  |  | <b>20f. (City or town)</b> <u>  </u>  |  | <b>(County)</b> <u>  </u>  |  | <b>(State)</b> <u>  </u>   |  |   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Jan 1962</u> <b>to</b> <u>Jan 27, 1967</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Jan 26, 1967</u> , <b>and that death occurred at</b> <u>9:15 M.</u> , <b>from the causes and on the date stated above.</b>   |  |   |  |  |  |  |  |   |  |  |  |  |  |   |  |
| <b>22a. SIGNATURE</b><br><u>B. B. Brambrough</u> M.D.  |  |   |  |  |  | <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>   |  | <b>22b. DATE SIGNED</b><br><u>1/27/67</u>                                     |  | <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>5609 Main St</u>           |  | <b>22d. ADDRESS</b><br><u>Elkridge, Md. 21227</u>  |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  |  |   |  | <b>23b. DATE THEREOF</b><br><u>1/30/67</u>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Lorraine Park Cemetery</u>   |  |   |  | <b>23d. LOCATION (City, town or county)</b><br><u>Woodlawn, D.C.</u> |  | <b>(State)</b> <u>  </u>   |  |   |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>Wm. J. Fickenshous</u>   |  |   |  |  |  | <b>ADDRESS</b><br><u>Baltimore, Md.</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br><u>JAN 30 1967</u>                          |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>            |  |  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00371

## CERTIFICATE OF DEATH

00374

|  |                                  |   |                                    |  |                                |   |  |
|--|----------------------------------|---|------------------------------------|--|--------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |                                |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Fort Howard</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>73 Days</b>   |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>   |                                |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Veterans Administration Hospital</b>  |                                  |   |                                    | d. STREET ADDRESS<br><b>1021 Vanderwood Road</b>   |                                | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>RAYMOND JOSEPH MULDOWNEY</b>  |                                  |   |                                    | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 20 19 67</b>  |                                |   |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/20/98</b> | 9. AGE (in years last birthday)<br><b>68</b> yrs   | IF UNDER 1 YEAR<br>Months Days | IF UNDER 24 HRS<br>Hours Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Marine Engineer</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Philadelphia, Pa.</b>  |                                | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Andrew Muldowney</b>   |                                  |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Nellie Driscoll</b>   |                                |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW I</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>169-18-0036</b>   |                                    | 17. INFORMANT Address<br><b>Clin. Rec. VA Hospital, Fort Howard, Maryland</b>  |                                |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio Respiratory Failure</b><br>345 X<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Decubitus Ulcers</b><br>DUE TO<br>(c) <b>Multiple Sclerosis</b> |                                  |   |                                    |  |                                | INTERVA. BETWEEN ONSET AND DEATH<br><b>24 Hours</b><br><b>1 1/2 Years</b><br><b>3 Years</b>       |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)  |                                  |   |                                    |  |                                | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                    |  |                                |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                                | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (a) (this hospital) attended the deceased from <b>11/8/</b> , 19 <b>66</b> , to <b>1/20/</b> , 19 <b>67</b> , that (b) (we) last saw the deceased alive on <b>1/20/</b> , 19 <b>67</b> , and that death occurred at <b>8:00 PM</b> from causes and on the date stated above.  |                                  |   |                                    |  |                                |   |  |
| 22a. SIGNATURE<br><b>Madhav D. Barhanpurkar</b>  |                                  |   |                                    | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>              |                                | 22b. DATE SIGNED<br><b>1/21/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MADHAV D. BARHANPURKAR</b>  |                                  |   |                                    | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |                                |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/24/1967</b>   |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Sepulchre</b>  |                                | 23d. LOCATION (City or Town) (County) (State)<br><b>Philda Pa</b>                                 |  |
| 24. FUNERAL DIRECTOR<br><b>Wm. J. Tickner &amp; Sons, Inc.</b>   |                                  | ADDRESS<br><b>North &amp; Pennsylvania Ave Baltimore, Maryland</b>  |                                    | 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>  |                                | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |





00372

CERTIFICATE OF DEATH

00375

|  |                                  |   |   |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                              |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |                                  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>103 La Paix Lane</u>  |                                  | d. STREET ADDRESS<br><u>103 La Paix Lane</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Elizabeth</u> Middle <u>G</u> Last <u>Murphy</u>   |                                  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>6</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>Female</u>  | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><u>WIDOWED</u> <input checked="" type="checkbox"/> <u>DIVORCED</u> <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>May 22, 1883</u> |
| 9. AGE (In years last birthday)<br><u>83</u> yrs.  |                                  | IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Baltimore, Maryland</u>   |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>U. S. A.</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY<br><u>U. S. A.</u>  |   |
| 13. FATHER'S NAME<br><u>Hammond</u>  |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Myra Grey</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                                  | 16. SOCIAL SECURITY NO. 17. INFORMANT<br><u>Mr. F. W. Bonhage 103 La Paix Lane Towson Md</u>  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u><br>DUE TO (b) <u>A-S heart disease</u><br>DUE TO (c) <u>  </u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 min</u><br><u>5 yrs</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)  |                                  |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <u>  </u> p.m. <u>  </u>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>9/19</u> , 19 <u>63</u> to <u>1/16</u> , 19 <u>67</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>1/3</u> , 19 <u>67</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.        |                                  |   |   |
| 22a. SIGNATURE<br><u>Norman R. Freeman</u> M.D.  |                                  | 22b. DATE SIGNED<br><u>1/9/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>NORMAN R. FREEMAN JR</u>  |                                  | 22d. ADDRESS<br><u>11 W 29th St</u>   |   |
| 23a. BURIAL, CREMATION, 23b. DATE THEREOF<br>REMOVAL (Specify)<br><u>Burial</u> <u>1/9/67</u>  |                                  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge</u>  |   |
| 23d. LOCATION (City, town or county) (State)<br><u>Pikesville, Md. Balto. Co.</u>  |                                  | 24. FUNERAL DIRECTOR'S SIGNATURE<br><u>Wm J. Tackert &amp; Son Inc 17 N La Ave</u>  |   |
| 25a. REC'D BY REGISTRAR<br><u>JAN 9 1967</u>   |                                  | 25b. REGISTRAR'S SIGNATURE<br><u>  </u>   |   |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00373

CERTIFICATE OF DEATH

00376

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>                   |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c LENGTH OF STAY IN 1b<br><b>2yr6mth27dys</b>  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore County, Maryland</b> |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |  | d STREET ADDRESS<br><b>7939 St. Gregory Drive</b>  | e IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                     |
| 3 NAME OF DECEASED (Type or print)<br>First <b>William</b> Middle <b>S.</b> Last <b>Murray</b>   |  | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>6</b> Year <b>19 67</b>   |  |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>  | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>9-29-92</b>  |
| 9. AGE (In years last birthday) yrs <b>74</b>  |  | F UNDER 1 YEAR<br>Months <b>7</b> Days <b>4</b>  | IF UNDER 24 HRS<br>Hours <b>1</b> Min <b>0</b>   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>steel worker</b>  |  | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel Co. Ohio</b>  | 11. BIRTHPLACE (County & State or foreign country)<br><b>U.S.</b>  |
| 13 FATHER'S NAME<br><b>Clark</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Hattie Tyson</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16. SOCIAL SECURITY NO<br><b>213-07-8127</b>   | 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic cardiac failure</b><br>DUE TO (b) <b>Arteriosclerotic cardiovascular disease with old myocardial infarction</b><br>DUE TO (c) <b>old myocardial infarction</b>                                  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Thrombosis of the vessel of left lower stump</b>  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>6-8-64</b> , 18:00 to <b>Jan. 6, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 6, 1967</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above |  |  |  |
| 22a. SIGNATURE<br><i>Stella Wachslar</i>   |  | 22b. DATE SIGNED<br><b>1-6-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>   |  | 22d. ADDRESS<br><b>Spring Grove State Hospital<br/>Catonsville, Maryland 21228</b>   |  |
| 23a. BURIAL, CREMATION, or other disposition (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-9-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bel Air Memorial</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Belair, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br><b>JOHN J. DUDA, Dundalk, Maryland 21222</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 10 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. [illegible]</i>  |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00374

## CERTIFICATE OF DEATH

00377

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The page remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTO.</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admision)<br>o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>                            |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>ESSEX</u>   |  | c. LENGTH OF STAY IN 1b<br><u>ESSEX</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>35 TERRACE RD.</u>  |  | d. STREET ADDRESS<br><u>8041 EDGEWATER</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>JOHN</u> Middle <u>A</u> Last <u>MUTH</u>   |  | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>29</u> Year <u>1967</u>  |   |
| 5. SEX<br><u>M</u>   | 6 COLOR OR RACE<br><u>W</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>AUG. 2, 1880</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 11 BIRTHPLACE (County & State, or foreign country)<br><u>MD.</u>   |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 13. FATHER'S NAME<br><u>THOMAS MUTH</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>—</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>   |  | 16 SOCIAL SECURITY NO<br><u>219-16-5351</u>  |   |
| 17 INFORMANT<br><u>ELIZABETH GERBER</u>  |  | Address<br><u>35 TERRACE</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIAL DECOMPENSATION</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ARTERIO-SCLEROTIC HEART</u><br>DUE TO<br>(c) <u>DISEASE</u> |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 DAY</u><br><br><u>14 YRS</u>                             |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>APR. 22, 1952</u> , to <u>JAN 29</u> , 1967, that (I) (we) last saw the deceased alive on <u>JAN 28</u> , 1967, and that death occurred at <u>7:30 A.M.</u> , from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><u>Joseph Miceli</u>   |  | 22b. DATE SIGNED<br><u>1/30/67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JOSEPA MICELI M.D.</u>  |  | 22d. ADDRESS<br><u>108 STAYLOR AVE ESSEX, MD. 21221</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>2/1/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>HOLY REDEEMER</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTO. MD</u>                                 |
| 24. FUNERAL DIRECTOR<br><u>J.G. CONNELLY SONS</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 31 1967</u>   |   |
| ADDRESS<br><u>300 MACE</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Julius J. Jones</u>   |   |



00375

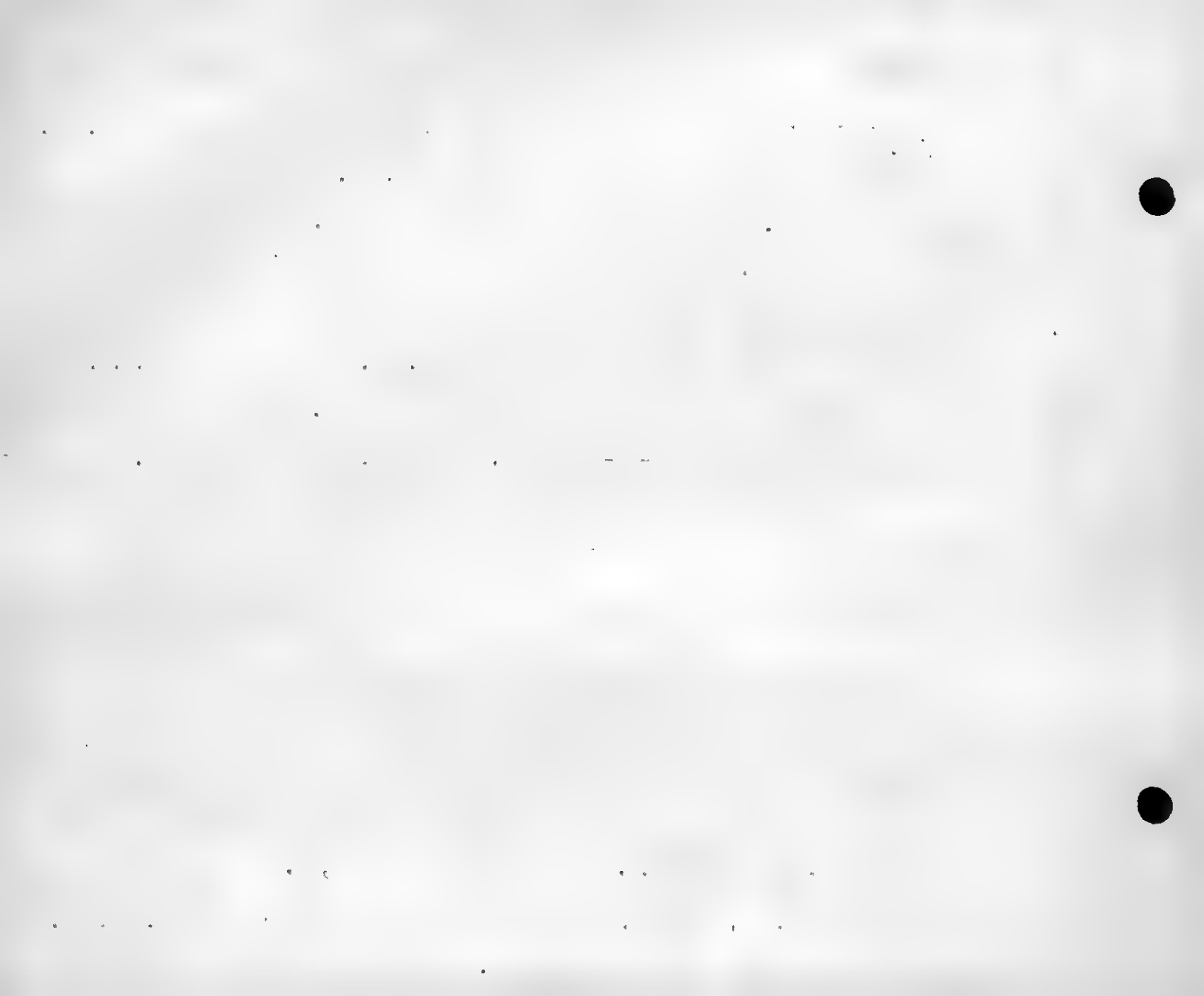
## CERTIFICATE OF DEATH

00378

|  |  |   |  |  |  |  |   |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto. Co.</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b>            |  |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparks</b>  |  |   | c. LENGTH OF STAY IN 15<br><b>18 years</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparks, Md.</b> |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Stringtown Rd.</b>  |  |   |  | d. STREET ADDRESS<br><b>Stringtown Rd.</b>   |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED (Type or print)<br><b>John G. Naylor</b>   |  |   |  | 4. DATE OF DEATH<br><b>January 15, 1967</b>  |  |  |   |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>July 31, 1876</b>   |   |
| 9. AGE (In years last birthday) yrs.<br><b>90</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days  |  | 11. IF UNDER 24 HRS.<br>Hours Min  |  |  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>  |  | 11. BIRTHPLACE (County & State or foreign country)<br><b>Balto. Co.</b>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |  |  |  |  |   |
| 13. FATHER'S NAME<br><b>Levi Naylor</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth E. Bull</b>   |  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO<br><b>213-50-7942</b>  |  | 17. INFORMANT Address<br><b>Mrs. Evelyn E. Bull Sparks, Md.</b>  |  |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br><b>35xx</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>3400</b> |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3400</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Arterio-sclerosis - C.V. Disease</b>   |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)   |  |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-12-67</b> to <b>1-15-67</b> , that (I) (we) last saw the deceased alive on <b>1-13-67</b> and that death occurred at <b>12:45</b> M, from causes and on the date stated above.  |  |   |  |  |  |  |   |
| 22a. SIGNATURE<br><b>M.C. Porterfield</b>  |  |   |  | 22b. DATE SIGNED<br><b>1-17-67</b>   |  |  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M.C. Porterfield, M.D.</b>  |  |   |  | 22d. ADDRESS<br><b>Hampstead, Md.</b>  |  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 23b. DATE THEREOF<br><b>Jan. 18, 1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Upperco, Balto. Co. Md.</b>                |   |
| 24. FUNERAL DIRECTOR ADDRESS<br><b>Tipton - Eline Funeral Home Hampstead, Md.</b>  |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 18 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





00376

CERTIFICATE OF DEATH

Reg. Dist. No. 00379

|  |                               |   |                                 |  |   |  |  |
|--|-------------------------------|---|---------------------------------|--|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                               |   |                                 | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY   |   |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                               |   |                                 | c. LENGTH OF STAY IN 1b  |   |  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>Caton Ridge Nursing Home</b>  |                               |   |                                 | d. STREET ADDRESS<br><b>835 Milford Mill Rd.<br/>Caton Ridge Nursing Home</b>  |   |  |  |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                               |   |                                 |  |   |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lena</b> Middle <b>Nell</b> Last   |                               |   |                                 | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>6</b> Year <b>1967</b>  |   |  |  |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>Wh</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1876</b> | 9. AGE (In years last birthday)<br><b>90</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min. | IF UNDER 24 HRS  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                               |   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                               |   |                                 |  |   |  |  |
| 13. FATHER'S NAME<br><b>--- Mulsheski</b>  |                               |   |                                 | 14. MOTHER'S MAIDEN NAME   |   |  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)   |                               |   |                                 | 16. SOCIAL SECURITY NO   |   |  |  |
| 17. INFORMANT<br><b>Dr. Arthur Bell</b><br><b>1009 Frederick Rd.</b>   |                               |   |                                 | Address  |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic Corruptive Heart Failure</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <b>ASCVD</b><br>DUE TO<br>(c) <b>Generalized Arteriosclerosis</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Bronch Syndrome</b> |                               |   |                                 |  |   |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |                               |   |                                 |  |   |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                               |   |                                 |  |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               |   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |  |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a. m. p. m. <b>19</b>  |                               |   |                                 | 20d. INJURY OCCURRED<br>White <input type="checkbox"/> Not white <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |
| 20f. (City or town)  |                               |   |                                 | (County)   |   | (State)  |  |
| 21. I certify that I attended the deceased from <b>2-15-1964</b> , to <b>1-6-1967</b> , that I last saw the deceased alive on <b>1-6-1967</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED  |                               |   |                                 |  |   |  |  |
| ACTUAL SIGNATURE <b>Cesar Valle Couero</b> M.D.  |                               |   |                                 |  |   |  |  |
| PHYSICIAN'S NAME (Type) <b>Cesar Cavero, M. D. - 8629 Liberty Rd.-Randallstown, Md.</b>  |                               |   |                                 |  |   |  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                               | 22b. DATE WHEREOF<br><b>1-10-67</b>   |                                 | 22c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cem.</b>  |   | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Witzke F. D.-4101 Edmondson Ave.</b>  |                               |   |                                 | 24a. REC'D BY REGISTRAR<br><b>JAN 9 1967</b>   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00377

## CERTIFICATE OF DEATH

00380

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <i>MD. Virginia</i> b. COUNTY <i>Virginia</i>              |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Catonville</i>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Virginia Beach</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>Ridgeway Manor Nursing Home</i>   |   | d. STREET ADDRESS   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <i>Josephine</i> Middle <i>C.</i> Last <i>Nelson</i>  |   | 4. DATE OF DEATH<br>Month <i>Jan.</i> Day <i>4</i> Year <i>1967</i>   |   |
| 5. SEX<br><i>female</i>  | 6. COLOR OR RACE<br><i>white</i>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>4-28-1886</i>  |
| 9. AGE (In years last birthday) <i>80</i> yrs.   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |   | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>   |   |
| 13. FATHER'S NAME<br><i>Samuel Dix</i>   |   | 14. MOTHER'S MAIDEN NAME<br><i>Sarah Carman</i>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><i>no</i>   |   | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><i>Roy L. Nelson</i>  |   | Address<br><i>7613 Perring Terrace</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <i>493X</i><br>DUE TO <i>Heart Failure</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c)    |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 week</i>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><i>Pneumonia</i>  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <i>19</i>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>19 Jan</i> , 19 <i>66</i> , to <i>4 Jan</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4 Jan</i> 19 <i>67</i> and that death occurred at <i>6:20 P.M.</i> from causes and on the date stated above. |   |   |   |
| 22a. SIGNATURE<br><i>William Goodman, M.D.</i>   |   | 22b. DATE SIGNED<br><i>5 Jan 67</i>   |   |
| 22c. PHYSICIAN'S NAME (Type) <i>WILLIAM GOODMAN, M.D.</i>  |   | 22d. ADDRESS<br><i>1334 Sulphur Rd - 21229</i>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>burial</i>   | 23b. DATE THEREOF<br><i>1-9-67</i>  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Forest Lawn Cem.</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>Norfolk, Virginia</i>                         |
| 24. FUNERAL DIRECTOR<br><i>Leonard J. Ruck Inc Baltimore, Md.</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>JAN 10 1967</i>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><i>W. J. Lee</i>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.



00378

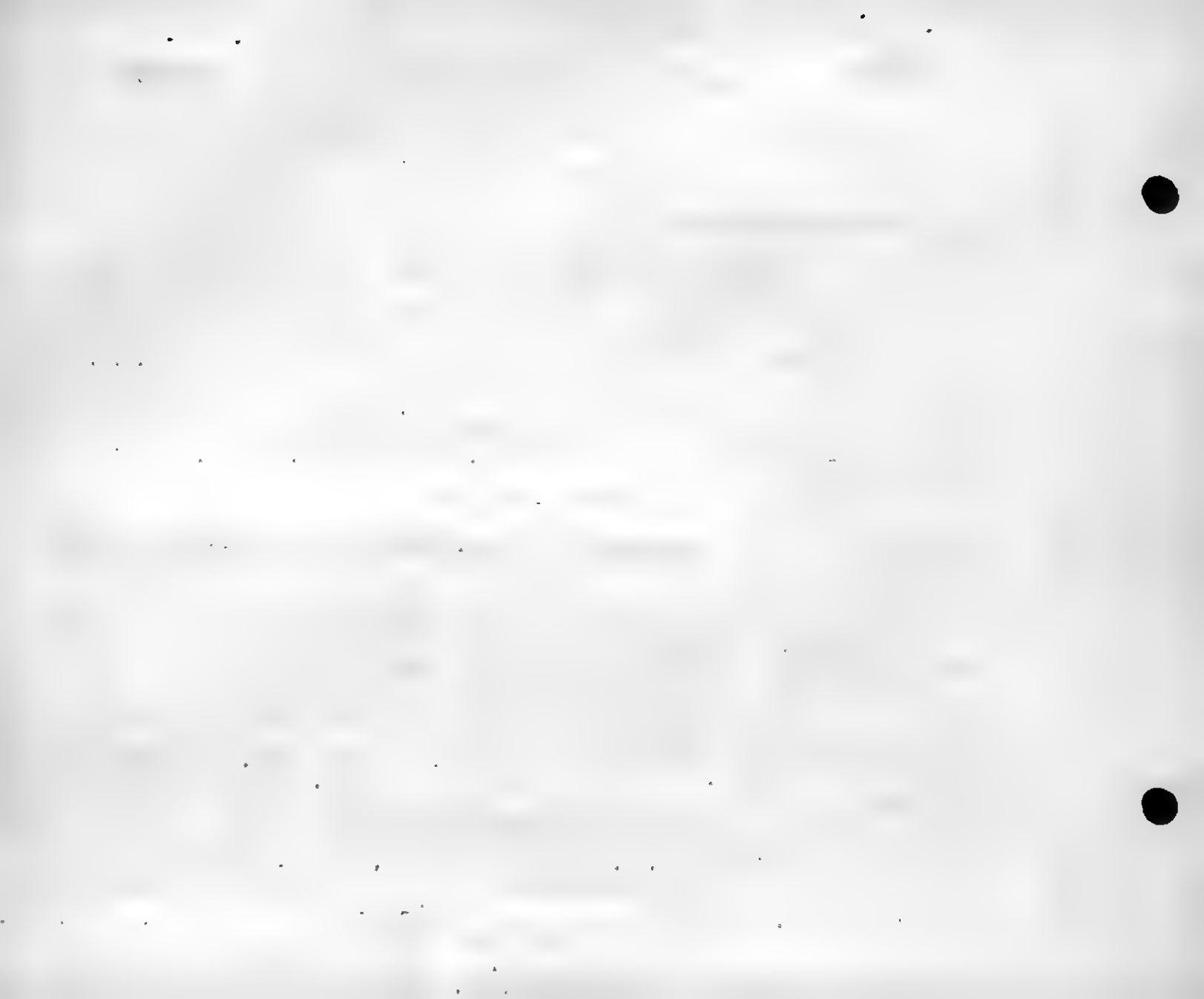
## CERTIFICATE OF DEATH

00381

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> ✓             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |   | c. LENGTH OF STAY IN 1b<br><b>222 DAYS</b>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>PASADENA</b>  |   | d. STREET ADDRESS<br><b>243 BODKIN AVENUE</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>THOMAS</b> Middle <b>EARL</b> Last <b>NORATEL</b>  |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>8</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>AUGUST 16, 1900</b>  |
| 9 AGE (n years last birthday) yts.<br><b>66</b>  |   | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> M.n. <input type="checkbox"/>           |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SHEET METAL WORKER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTIMORE, MARYLAND</b>   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>THOMAS NORATEL</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>ELLA C. DRIVER</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW-1</b>   |   | 16. SOCIAL SECURITY NO.<br><b>215 09 1167</b>   |   |
| 17. INFORMANT<br><b>CLIN. REC., VAH, FT. HOWARD, MARYLAND</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>PNEUMONIA; BILATERAL</b><br>DUE TO<br>162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>BRONCHOBENIC CARCINOMA LEFT LUNG WITH METASTASIS</b><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b><br><b>UNKNOWN</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>MYOCARDIAL INFARCTION, OLD</b>  |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <input type="checkbox"/> p.m. <input type="checkbox"/> <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (A) (this hospital) attended the deceased from <b>May 31, 1966</b> , to <b>Jan. 8, 1967</b> , that (A) (we) last saw the deceased alive on <b>Jan. 8, 19 67</b> , and that death occurred at <b>11:08 a.m.</b> from causes and on the date stated above.  |   |   |   |
| 22a. SIGNATURE<br><b>George Dudas, M.D.</b>  |   | 22b. DATE SIGNED<br><b>19 67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>GEORGE DUDAS, M. D.</b>   |   | 22d. ADDRESS<br><b>VAH, Ft. Howard, Maryland</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jan. 12, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Mem. Pk. CEMETERY</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Glen Burnie, A. A. Co., Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>George J. Lince</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 16 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00379

CERTIFICATE OF DEATH

00382

|  |                              |   |                                      |   |   |   |  |
|--|------------------------------|---|--------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore,</b> MARYLAND  |                              |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b> |   |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |                              |   | c. LENGTH OF STAY IN 1b              |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>College Manor Nursing Home</b>  |                              |   |                                      | d. STREET ADDRESS<br><b>922 Army Road</b>   |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>Alexander Murdoch Norris</b>   |                              |   |                                      | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>25th.</b> Year <b>1967</b>  |   |   |  |
| 5. SEX<br><b>M</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/30/1886</b> |   | 9. AGE (In years last birthday) yrs.<br><b>80</b> | 10. IF UNDER 1 YEAR<br>Months <b></b> Days <b></b> Hours <b></b> Min <b></b>                      |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired-Engineer</b>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Balto. Aircoil</b>  |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Edward T. Norris</b>   |                              |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Murdoch</b>   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WWI &amp; WWII</b>   |                              | 16. SOCIAL SECURITY NO.<br><b>212-18-4261A</b>  |                                      | 17. INFORMANT<br><b>Allan T. Norris</b>   |   | Address<br><b>(Same)</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Atherosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO<br>(c) |                              |   |                                      |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |                              |   |                                      |   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |                                      |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b></b>   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb</b> , 19 <b>63</b> to <b>1-25</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-3-67</b> , and that death occurred at <b>2 P.M.</b> from causes and on the date stated above.                  |                              |   |                                      |   |   |   |  |
| 22a. SIGNATURE<br><b>William G. Helfrich</b> M.D.  |                              |   |                                      | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>         |   | 22b. DATE SIGNED<br><b>1-26-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. William G. Helfrich</b>   |                              |   |                                      | 22d. ADDRESS<br><b>5006 Roland Ave.</b>   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              | 23b. DATE THEREOF<br><b>1/27/1967</b>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |                              |   |                                      | ADDRESS<br><b>4905 York Rd. Baltimore, 12, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 26 1967</b>  |  |
|  |                              |   |                                      | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. [Signature]</b>   |   |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00380

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00383

|  |                                     |  |  |
|--|-------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>co</u> MARYLAND  |                                     | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u> <u>co</u>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Towson</u>  |                                     | c. LENGTH OF STAY IN 1b<br><u>Towson</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>379 HILLEN Rd</u>   |                                     | d. STREET ADDRESS<br><u>379 HILLEN Rd</u>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <u>Henrietta Ora</u> <u>Norris</u>   |                                     | 4 DATE OF DEATH<br>Month <u>1</u> Day <u>8</u> Year <u>1967</u>  |  |
| 5 SEX<br><u>F</u>  | 6 COLOR OR RACE<br><u>Negro</u>     | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>Sept 15, 1911</u> <u>58</u> yrs                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Dom</u>  |                                     | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (State or foreign country)<br><u>Harford co</u>  |                                     | 12 CITIZEN OF WHAT COUNTRY<br><u>USA</u>   |  |
| 13 FATHER'S NAME<br><u>James Gray</u>  |                                     | 14 MOTHER'S MAIDEN NAME<br><u>Ada</u>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)  |                                     | 16 SOCIAL SECURITY NO<br><u>none</u>   |  |
| 17 INFORMANT<br><u>Ralph Norris</u>  |                                     | Address  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Sudden</u><br>DUE TO (b) <u>Atherosclerotic Cardiovascular Disease</u><br>stating the underlying cause last (c) <u>Diabetes Mellitus</u>   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><u>10 yrs</u>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                                     | 19 WAS AUTOPSY PERFORMED?<br><u>YES</u> <input type="checkbox"/> <u>NO</u> <input type="checkbox"/>  |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |                                     | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   |                                     | 20d. INJURY OCCURRED<br>While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)   |                                     | 20f. (City or town) (County) (State)   |  |
| 21 I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                                     |  |  |
| ACTUAL SIGNATURE<br><u>Charles F. O'Donnell</u> M.D.   |                                     | 22. DATE SIGNED  |  |
| EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>   |                                     | Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1-11-67</u> | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Clark Chapel</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Calma Harford md</u> |
| 24 FUNERAL DIRECTOR<br><u>George W TITTLE</u>  |                                     | 25a. REC'D BY REG STRAR<br><u>Bel Air md</u>   |  |
| 25b. REG STRAR'S SIGNATURE<br><u>Charles Judge</u>   |                                     | DATE <u>JAN 12 1967</u>  |  |



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00381

CERTIFICATE OF DEATH

00384

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>               |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 1b<br><b>30.4</b>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Ridgeway Manor Nursing Home</b>  |  | d. STREET ADDRESS<br><b>3708 Clarenell Road</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>ROBERT J. NORWOOD</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>10</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-20-1889</b>                                       |
| 9 AGE (in years last birthday) yrs <b>77</b>   |  | IF UNDER 1 YEAR Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Clerk</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>William B. Norwood</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Morrison</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>714-03-4573</b>  |   |
| 17. INFORMANT<br><b>Mrs. Ida E. Johnson, 3708 Clarenell Road</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>422.1 ASCVD</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND. ON GIVEN IN PART I (a) <b>diabetes mellitus</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 9</b> , 1967 to <b>Feb 10</b> , 1967, that (I) (we) last saw the deceased alive on <b>Jan 9</b> , 1967, and that death occurred at <b>11:00 P.M.</b> from causes and on the date stated above   |  |  |   |
| 22a. SIGNATURE<br><b>Earl I. Pass</b>  |  | 22b. DATE SIGNED<br><b>1-11-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Earl I. Pass</b>  |  | 22d. ADDRESS<br><b>4001 Wilkens Avenue, Balto., Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-14-1967</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 12 1967</b>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1 (M)

00382

CERTIFICATE OF DEATH

00385

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |   | c. LENGTH OF STAY IN 1b<br><b>3 weeks</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Dulaney Towson Nursing Home</b>  |   | d. STREET ADDRESS<br><b>806 Scarlett Drive</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>GRACE EDWARDS OLMSTEAD</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>Jan. 21 19 67</b>  |  |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Sept. 9, 1884</b>                                   |
| 9. AGE (n years last birthday) yrs<br><b>82</b>   |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  | 11. IF UNDER 24 HRS<br>Months Days Hours Min                               |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>not employed</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>not employed</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Dexter, Iowa</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Edwin Edwards</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Annie Louise Mount</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |   | 16. SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Mr. Merlin Olmstead (son)</b>   |   | Address<br><b>Same as 2-D</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>GENERALIZED ARTERIO SCLEROSIS</b><br>DUE TO<br>(c) |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>APP-1WK</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 11</b> , 19 <b>60</b> to <b>JAN 21</b> , 1967, that (I) (we) last saw the deceased alive on <b>JAN 20</b> , 1967, and that death occurred at <b>3:45</b> M, from causes and on the date stated above.   |   |   |  |
| 22a. SIGNATURE<br><b>T. C. Siwinski</b>   |   | 22b. DATE SIGNED<br><b>1/23/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>T. C. Siwinski, M.D.</b>  |   | 22d. ADDRESS<br><b>206 W. Pennsylvania Ave., Towson, Md.</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jan. 24, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Suitland, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |   |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

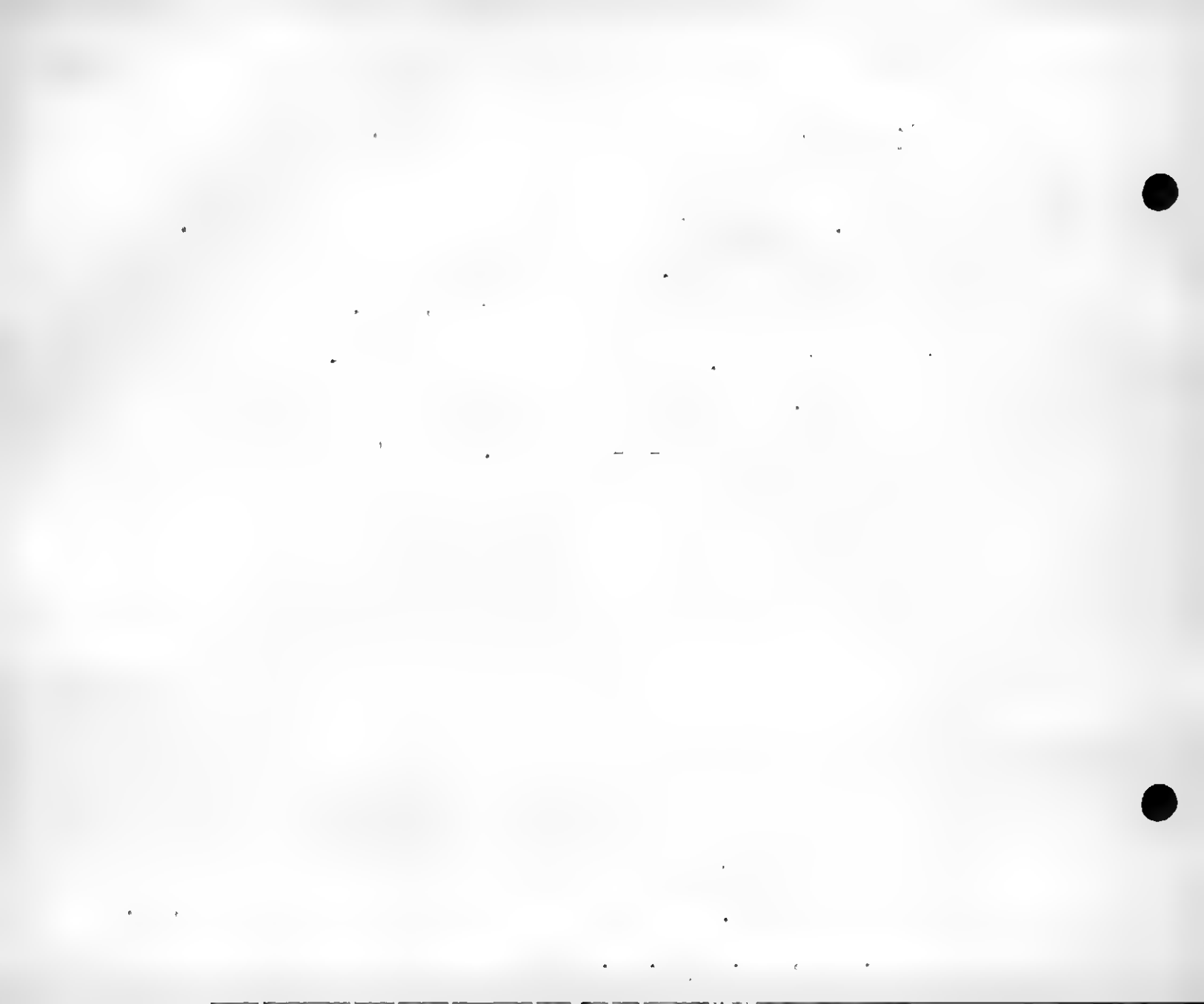
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00383

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00386

|   |                              |   |  |   |   |  |   |
|---|------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Balto. (Towson)</b> MARYLAND  |                              |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore #14</b> |   |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore #14</b>  |                              |   | c. LENGTH OF STAY N 16   |   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore #14</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                              |   |  | d. STREET ADDRESS<br><b>3037 Northern Pkwy.</b>   |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)<br><b>William C. O'Malley</b>   |                              |   |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>3</b> Year <b>19 67</b>   |   |  |   |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>March 7, 1897.</b>  |   | 9. AGE (In years last birthday)<br><b>69</b> yrs          |  | 10. IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>19</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Auditing Dept.</b>  |                              |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>I &amp; O R R</b>                                  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Mass.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |
| 13. FATHER'S NAME<br><b>Unk. O'Malley</b>   |                              |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>Yes</b>   |                              | 16. SOCIAL SECURITY NO<br><b>705-95-2592</b>  |  | 17. INFORMANT<br><b>Mrs. Maude O'Malley</b>   |   | Address<br><b>(Same)</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a).<br>stating the underlying cause lost. (b) <b>Sudden</b><br>(c)  |                              |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>            |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                              |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) |   |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                              | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)   |   |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                              |   |  |   |   |  |   |
| ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.   |                              |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |   |  |   |
| EXAMINER'S NAME (Type) <b>Charles F. O'Donnell, M.D.</b>  |                              |   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |   |  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                              |   |  | 23b. DATE THEREOF<br><b>1/6/67.</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cemetery</b>                                 |   |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |                              |   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>  |   | 22. DATE SIGNED<br><b>1/3/67</b>   |   |
| 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 1967</b>   |                              |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |  |   |





DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00384

00387

|  |  |   |  |   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN lb<br><b>2 1/2 yrs</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Stella Maris Hospital</b>   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b><br>d. STREET ADDRESS<br><b>106 E. WEST STREET</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>PT. REV. FRI LEO OTTERBEIN</b><br>(Msgr) <b>Leo Otterbein</b>  |  |   |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>9</b> Year <b>1967</b>  |  |   |  |
| 5. SEX<br><b>M</b>   |  | 6. COLOR OR RACE<br><b>W</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>10/5/81</b>  |  |
| 9. AGE (In years last birthday) <b>85</b> yrs.   |  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>9</b>  |  | IF UNDER 24 HRS.<br>Hours <b>19</b> Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Roman Catholic Priest</b>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>ROMAN CHURCH</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |   |  |   |  |
| 13. FATHER'S NAME<br><b>Adam Otterbein</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Simon</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>220-14-8868</b>   |  | 17. INFORMANT<br><b>Hospice records</b>                                     |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ASCVD</b><br><b>7/22/1</b> DUE TO <b>Serious</b><br>Conditions, if any, which gave rise to immediate cause (b) DUE TO <b>Serious</b><br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 5, 1964</b> to <b>Jan. 9, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 9, 1967</b> and that death occurred at <b>2:25 PM</b> from the causes and on the date stated above.  |  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Robert J. Mahon</b>   |  |   |  | 22b. DATE<br><b>1/9/67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Robert J. Mahon, M.D.</b>                |  |
| 22d. ADDRESS<br><b>204 E Joppa Rd. Towson</b>  |  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>1/13/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>HOLY CROSS CEMETERY</b>  |  | 23d. LOCATION (City, town or county) (State)<br><b>RITCHIE HIGHWAY</b>      |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>H. W. MEARS &amp; SON</b>   |  |   |  | 25a. REC'D BY REGISTRAR<br><b>JAN 16 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                          |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00385

## CERTIFICATE OF DEATH

00388

|  |  |  |  |
|--|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY                                    |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |  | c LENGTH OF STAY in ib<br><b>2yr3mth12dys</b>  | c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Balti more</b> |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>610 Old North Point Road</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Thomas Gwinn Palmer</b>   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>January 4 19 67</b>   |  |
| 5 SEX<br><b>male</b>   | 6 COLOR OR RACE<br><b>white</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>March 2, 1921</b>  |
| 9. AGE (In years last birthday)<br><b>45</b> yrs   |  | F UNDER 1 YEAR<br>Months Days Hours Min  |  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>hospital attendant</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S.</b>   |  |
| 13. FATHER'S NAME<br><b>Harrison S. Palmer</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ethel</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>yes Navy</b>  |  | 16. SOCIAL SECURITY NO.<br><b>235-28-0827</b>  |  |
| 17 INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |  | Address  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac failure</b><br><b>527.1</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Cor pulmonale</b><br>DUE TO<br>(c) <b>Pulmonary emphysema</b> |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>Sept. 22, 1963</b> to <b>Jan. 4, 1967</b> , that <del>he</del> (we) lost the deceased alive on <b>Jan. 4, 1967</b> , and that death occurred at <b>8:00</b> M, from causes and on the date stated above.  |  |  |  |
| 22a. SIGNATURE<br><b>Stella Wachslar</b>   |  | 22b. DATE SIGNED<br><b>1-4-67</b>  |  |
| 22c PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>  |  | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>Jan. 8, 1967</b>  | 23c NAME OF CEMETERY OR CREMATORY<br><b>Miller's Cemetery</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Webster Springs, W. Va.</b>                       |
| 24 FUNERAL DIRECTOR<br><b>Robert Lemmon</b>  |  | 25a REC'D BY REGISTRAR<br>DATE <b>JAN 6 1967</b>   |  |
| ADDRESS<br><b>4611 Park Heights, Balto. Md.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00386

## CERTIFICATE OF DEATH

00389

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>        |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c LENGTH OF STAY IN 1b<br><b>3 months</b>  |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |  | e STREET ADDRESS<br><b>8138 Balto. Blvd. College Park</b>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <b>Fred Paragon</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>29</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>2-25-87</b>   |
| 9 AGE (In years last birthday)<br><b>79</b> yrs  |  | 10 IF UNDER 1 YEAR<br>Months <b>12</b> Days <b>29</b> Hours <b>19</b> Min.   |   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>unknown</b>   |  | 10b KIND OF BUSINESS OR INDUSTRY<br><b>unknown</b>   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Prince George's Co. Md.</b>   |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>Briton Paragon</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary ?</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>?</b>  |  | 16. SOCIAL SECURITY NO<br><b>520-24-2705A</b>  |   |
| 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b><br>DUE TO (b) <b>Arteriosclerosis, generalized and severe</b><br>DUE TO (c) <b>Arteriosclerosis, generalized and severe</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |   |
| 19. INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |  |  |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |   |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town) (County) (State)   |
| 21. I certify that (this hospital) attended the deceased from <b>10-29-66</b> , 19 <b>66</b> to <b>Jan. 29</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>Jan. 29</b> , 19 <b>67</b> , and that death occurred at <b>12:30</b> M, from causes and on the date stated above.  |  |  |   |
| 22a. SIGNATURE<br><b>Stella Wachslar</b>   |  | 22b. DATE SIGNED<br><b>2-1-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>   |  | 22d. ADDRESS<br><b>Spring Grove State Hospital<br/>Catonsville, Maryland 21228</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b DATE THEREOF<br><b>2/2/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Ritchie Highway Balto. Md.</b> |
| 24 FUNERAL DIRECTOR<br><b>KRAUSE FUNERAL HOME 1216 S. Charles St.</b>  |  | 25a REC'D BY REGISTRAR<br><b>FEB 6 1967</b>  |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>   |   |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00387

CERTIFICATE OF DEATH

00390

|   |  |   |  |
|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b>            |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural- Catonsville</b>   |  | c. LENGTH OF STAY IN 1b<br><b>Catonsville, Md.</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>House of Pines-Catonsville, Md.</b>  |  | d. STREET ADDRESS<br><b>203 Garden Ridge Rd.</b>  |  |
| 3. NAME OF DECEASED (Type or print)<br><b>John Pascoe</b>   |  | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>29</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/9/1893</b>  |
| 9. AGE (in years last birthday)<br><b>73</b> yrs  |  | 10. IF UNDER 24 HRS<br>Months <b>7</b> Days <b>3</b> Hours <b>19</b> Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Machinist</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Balt. Transit Co.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Unknown</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes W.W. I</b>  |  | 16. SOCIAL SECURITY NO.<br><b>213-10-0069</b>   |  |
| 17. INFORMANT<br><b>Mrs. Mary B. Pascoe</b>   |  | Address <b>8301 Charmel Drive 21207</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial Disorganization</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Arteriosclerotic Cardio-Vascular Disease</b><br>DUE TO<br>(c) |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 mo.</b><br><b>5 yrs.</b>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>19</b> o.m. p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12-5-</b> , 19 <b>64</b> , to <b>1-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1-28</b> 19 <b>67</b> , and that death occurred at <b>2:50</b> P.M. from causes and on the date stated above  |  |   |  |
| 22a. SIGNATURE<br><b>Wilmer K. Gallagher</b>  |  | 22b. DATE SIGNED<br><b>1/31/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Wilmer K. Gallagher</b>  |  | 22d. ADDRESS<br><b>6209 Frederick Rd. 21228 Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>2/1/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Oaklawn Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Eastern Ave. Balt. Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Loring Byers -8728 Liberty Rd. Randallstown, Md.</b>   |  | 25a. REC'D BY REGISTRAR<br><b>FEB 2 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00388

## CERTIFICATE OF DEATH

00392

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. LENGTH OF STAY IN 1b<br><b>3yrsldy</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |   | d. STREET ADDRESS<br><b>Waldorf, Maryland</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Henry Portzen</b>   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>5</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF B RTH<br><b>11-14-74</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>TOBACCO</b>   | 9. AGE (In years last birthday) yrs<br><b>92</b>  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Luxembourg</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |   |
| 13. FATHER'S NAME<br><b>Nicolas Portzen</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Strice</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |   | 16. SOCIAL SECURITY NO<br><b>219-54-3276</b>  |   |
| 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>  |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>422.1</b><br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>(b) <b>Arteriosclerotic cardiovascular heart disease</b><br>DUE TO<br>(c) <b>Generalized arteriosclerosis</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>Senility - Malnutrition</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-4-63</b> , 19 <b>63</b> to <b>Jan. 5</b> , 1967, that (we) last saw the deceased alive on <b>Jan. 5</b> , 19 <b>67</b> and that death occurred at <b>5:30</b> M, from causes and on the date stated above.           |   |   |   |
| 22a. SIGNATURE<br><b>Stella Wachslar</b>  |   | 22b. DATE SIGNED<br><b>1-5-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>  |   | 22d. ADDRESS<br><b>Spring Grove State Hospital<br/>Catonsville, Maryland 21228</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1-9-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ST PETERS CEM.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>WALDORF, MD.</b>                              |
| 24. FUNERAL DIRECTOR<br><b>South Funeral Home, Waldorf, Md</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1967</b>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00389

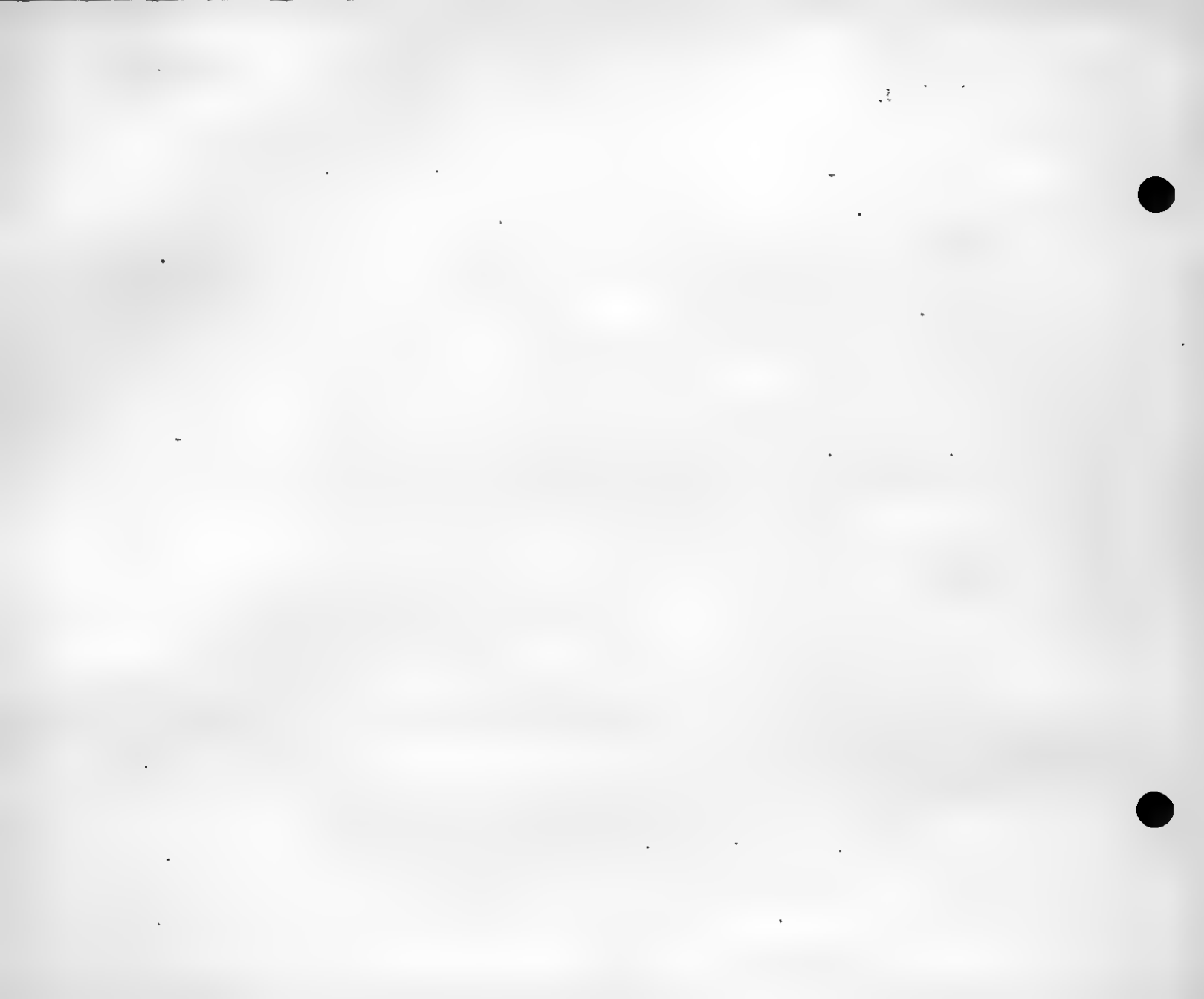
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00393

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><u>Catonsville</u>                           |  |  |  | c. LENGTH OF STAY IN 1b<br><u>Lutherville</u>  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Ridgeway Nursing Home 5743 Edmondson Ave.</u> |  |  |  | e. STREET ADDRESS<br><u>1426 Burton Ave.</u>   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Nellie</u> Middle <u>Alice</u> Last <u>Powers</u>                                |  |  |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>10</u> Year <u>1967</u>  |  |  |  |
| 5. SEX<br><u>Female</u>  |  | 6. COLOR OR RACE<br><u>White</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><u>May 4, 1871</u>   |  |
| 9. AGE (In years last birthday)<br><u>95</u> yrs.  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>At Home</u>                                      |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Rhode Island</u>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>  |  | 13. FATHER'S NAME<br><u>Henry Powers</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Flora Mackay</u>  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>  |  |
| 16. SOCIAL SECURITY NO.<br><u>None</u>   |  | 17. INFORMANT<br><u>Family Records</u>   |  | Address  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Heart Failure</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>(c) _____                |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  | 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   |  |
| 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                        |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  | 21. I certify that (I) (this hospital) attended the deceased from <u>1 Nov -</u> , 19 <u>66</u> , to <u>10 Jan</u> , 19 <u>67</u> , that (I) (two) last saw the deceased alive on <u>6 Jan</u> , 19 <u>67</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above. |  |
| 22a. SIGNATURE<br><u>William Goodman, M.D.</u>   |  | 22b. DATE SIGNED<br><u>12 Jan 67</u>   |  | 22c. PHYSICIAN'S NAME (Type)<br><u>William Goodman</u>   |  | 22d. ADDRESS<br><u>1334 Sulphur Spring Rd - 2122</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  | 23b. DATE THEREOF<br><u>Jan. 13, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Prospect Hill Cemetery</u>  |  | 23d. LOCATION (City, town or county) (State)<br><u>Towson, Maryland</u>  |  |
| 24. FUNERAL DIRECTOR<br><u>John Burns' Sons, Towson, Maryland</u>  |  | 25a. REC'D BY REGISTRAR<br><u>Charles Judge</u>  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  | DATE JAN 13 1967   |  |



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00390

## CERTIFICATE OF DEATH

00394

|   |                                  |   |   |
|---|----------------------------------|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm ssion)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                  | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Jessup 20794</b> |
| d. NAME OF HOSPITAL OR INST TUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                  | d. STREET ADDRESS<br><b>224 Mission Road</b>  |   |
| e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                  |   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Matthew</b> Middle <b>Gregory</b> Last <b>PRESTIANNI</b>   |                                  | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>27</b> Year <b>19 67</b>   |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>January 27, 1967</b>   |
| 9. AGE (In years last birthday) yrs<br><b>40</b>  |                                  | 10. IF UNDER 1 YEAR<br>Months <b>40</b> Days <b>40</b> Hours <b>40</b>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11 BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Maryland</b>   |                                  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13 FATHER'S NAME<br><b>Joseph Prestianni</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Anna Sullivan</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                  | 16. SOCIAL SECURITY NO.   |   |
| 17. INFORMANT<br><b>Mr. Joseph G. Prestianni, 224 Mission Rd.</b>   |                                  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Hydrops fetalis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Erythroblastosis fetalis</b><br>DUE TO<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  | 19 WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   |                                  | 20f. (City or town) (County) (State)  |   |
| 21. I certify that <del>(x)</del> (this hospital) attended the deceased from <b>1/27</b> , 1967, to <b>1/27</b> , 1967, that <del>(b)</del> (we) last saw the deceased alive on <b>1/27</b> , 1967, and that death occurred at <b>1:47 P.M.</b> from causes on and on the date stated above.                              |                                  |   |   |
| 22a. SIGNATURE<br><i>Lawrence J. Misanik</i>  |                                  | 22b. DATE SIGNED<br><b>1-27-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Lawrence J. Misanik</b>  |                                  | 22d. ADDRESS<br><b>7620 York Rd., Towson, Md. 21204</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                  | 23b. DATE THEREOF<br><b>1-28-1967</b>   |   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Lawrence Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Howard County, Maryland</b>   |   |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Avenue 21229</b>   |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 31 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. J...</i>  |                                  |   |   |



00391

CERTIFICATE OF DEATH

00395

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><i>Rural - Rosedale</i>  |   | c. LENGTH OF STAY IN lb<br><i>10 yrs.</i>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><i>8019 Philadelphia Road</i>  |   | e. STREET ADDRESS<br><i>1225 Spring Avenue</i>  |   |
| 3. NAME OF DECEASED (Type or print)<br><i>Joseph A. Priller</i>  |   | 4. DATE OF DEATH<br>Month <i>January</i> Day <i>28</i> Year <i>1967</i>   |   |
| 5. SEX<br><i>Male</i>  | 6. COLOR OR RACE<br><i>White</i>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>March 20, 1918</i>   |
| 9. AGE (In years, months, days)<br><i>48</i> yrs   |   | 10. IF UNDER 1 YEAR<br>Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Paint Tinter</i>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><i>Brungr Paint Co.</i>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>Maryland</i>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |   |
| 13. FATHER'S NAME<br><i>Clement Priller</i>  |   | 14. MOTHER'S MAIDEN NAME<br><i>Katherine</i>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)<br><i>Yes WW II</i>   |   | 16. SOCIAL SECURITY NO<br><i>213 01 1452</i>  |   |
| 17. INFORMANT<br><i>Donothy V. Priller</i>   |   | Address<br><i>1225 Spring Ave.</i>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i><br>DUE TO (b) <i>Arteriosclerotic Coronary Artery Disease</i><br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <i>19</i> p.m.   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>1/28</i> , 1967, that (I) (we) last saw the deceased alive on <i>1/28</i> , 1967, and that death occurred at <i>9 A.M.</i> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><i>John G. Orth, M.D.</i>  |   | 22b. DATE SIGNED<br><i>1-28-67</i>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><i>John G. Orth M.D.</i>   |   | 22d. ADDRESS<br><i>8019 Philadelphia Road</i>   |   |
| 23a. BURIAL, CREMATION, REMOVA. (Specify)<br><i>Burial</i>   | 23b. DATE THEREOF<br><i>Jan. 31, 1967</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Holy Redeemer Cemetery</i>   | 23d. LOCATION (City or Town) (County) (State)<br><i>Baltimore, Maryland</i>                       |
| 24. FUNERAL DIRECTOR<br><i>Thos F. Carach</i>  |   | 25a. REC'D BY REGISTRAR<br>DATE <i>JAN 31 1967</i>  |   |
| ADDRESS<br><i>1211 Chesaco Avenue</i>  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John G. Orth</i>   |   |





1

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00392

Item 2 Film 33-1726767 rh

CERTIFICATE OF DEATH

00396

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |                                      |  |   |
|---|--------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>   |                                      | c. LENGTH OF STAY IN 1b  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson 21204</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>  |                                      | d. STREET ADDRESS <b>This is her usual residence</b><br><b>7620 York Road-21204</b>  |   |
| 3 NAME OF DECEASED (Type or print) <b>Sister M. Agnes Angela OSF( Proctor )</b>   |                                      | 4 DATE OF DEATH <b>January 18 19 67</b>  |   |
| 5 SEX <b>Female</b>   | 6 COLOR OR RACE <b>White</b>         | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <b>1-9-07</b>   |
| 9 AGE (In years last birthday) <b>60</b> yrs  |                                      | F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Religious</b>   |                                      | 10b. KIND OF BUSINESS OR INDUSTRY  |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>Philadelphia, Penn.</b>  |                                      | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |
| 13. FATHER'S NAME <b>Joseph Proctor</b>   |                                      | 14. MOTHER'S MAIDEN NAME <b>Bridget Lagan</b>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |                                      | 16 SOCIAL SECURITY NO.   |   |
| 17 INFORMANT <b>Sister Pierre,</b> Address <b>(Same)</b>  |                                      |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Massive Pulmonary Embolism</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>(b)<br>(c) |                                      |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Carcinoma of Right breast with extensive metastasis to ribs.</b>   |                                      |  | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                      | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                      | 20d INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)                                   |
| 20f (City or town) (County) (State)   |                                      |  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 25 1966</b> to <b>Jan. 18 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan. 18 1967</b> , and that death occurred at <b>5:30</b> M, from causes and on the date stated above.                         |                                      |  |   |
| 22a. SIGNATURE<br><b>Ernesto A. Hipolito</b>  |                                      | 22b. DATE SIGNED<br><b>Jan. 18 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Ernesto A. Hipolito MD</b>  |                                      | 22d. ADDRESS<br><b>7620 York Road, Towson 21204, Maryland.</b>   |   |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1/21/67.</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                                  |
| 24 FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |                                      | 25a REC'D BY REGISTRAR<br><b>JAN 23 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |                                      |  |   |



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| <div>1</div> <div>00393</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>00397</div>  |  |  |  |  |  |  |  |   |  |  |  |
|---|--|--|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> <u>MARYLAND</u>   |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>   |  |  |  |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>  |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2522 LIBERTY PARKWAY</u>  |  |  |  |  |  | d. STREET ADDRESS <u>2522 LIBERTY PKWY</u>   |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>J. HARRY PROWELL</u>   |  |  |  |  |  | 4. DATE OF DEATH <u>JAN 8 1967</u>   |  |   |  |  |  |
| 5. SEX <u>MALE</u>  |  | 6. COLOR OR RACE <u>WHITE</u>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | B. DATE OF BIRTH <u>NOV 18 1887</u>  |  | 9. AGE (In years last birthday) <u>79</u> yrs.                    |  | IF UNDER 1 YEAR Months Days            |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ORDER CLERK</u>  |  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>DELANA</u> |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> |  |
| 13. FATHER'S NAME <u>WILLIAM R. PROWELL</u>   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>JENNIE ELCOCK</u>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |  |  |  |  |  | 16. SOCIAL SECURITY NO. <u>MISS RUTH PROWELL 2522 LIBERTY PKWY</u>   |  | 17. INFORMANT Address   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of Right Lung C</u><br>163X DUE TO (b) <u>Metastasis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) |  |  |  |  |  |  |  |   |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |  |  |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>   |  |  |  |  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1 1966</u> to <u>Jan 8 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 7 1967</u> , and that death occurred at <u>6:15 PM</u> from the causes and on the date stated above.   |  |  |  |  |  |  |  |   |  |  |  |
| 22a. SIGNATURE <u>M. B. DAVIS</u>   |  |  |  |  |  | 22b. DATE SIGNED <u>1/9/67</u>   |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>M. B. DAVIS M.D.</u>  |  |  |  |  |  | 22d. ADDRESS <u>6800 MORNINGTON ROAD</u>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>1/11/67</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>   |  | 23d. LOCATION (City, town or county) (State) <u>BROOKLYN MD</u>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>WILLIAM FUNERAL HOME - DUNDALK MD</u>   |  |  |  |  |  | 25a. REC'D BY REGISTRAR <u>Charles Judge</u>   |  | 25b. REGISTRAR'S SIGNATURE  |  | DATE <u>JAN 12 1967</u>                |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1. and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00394

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00391

|   |                                  |  |                                   |
|---|----------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore,</u><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>                           |                                   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  |                                  | c. LENGTH OF STAY IN ID<br><u>3 days</u>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><u>Greater Baltimore Medical Center</u>   |                                  | d. STREET ADDRESS<br><u>2803 Garrison Blvd.</u>  |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>SUSIE H. PURNELL</u> Middle <u>(PERNELL)</u> Last   |                                  | 4. DATE OF DEATH<br>Month <u>Jan.</u> Day <u>6</u> Year <u>1967</u>  |                                   |
| 5. SEX<br><u>Female</u>   | 6. COLOR OR RACE<br><u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>              | 8. DATE OF BIRTH<br><u>7-4-94</u> |
| 9. AGE (In years) <u>72</u> (Month) <u>12</u> (Day) <u>19</u>   |                                  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Virginia</u>  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |                                   |
| 13. FATHER'S NAME<br><u>Unknown</u>   |                                  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)   |                                  | 16. SOCIAL SECURITY NO.  |                                   |
| 17. INFORMANT<br><u>Med. Record</u>   |                                  | Address  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>RESPIRATORY OBSTRUCTION</u><br>DUE TO <u>Carcinoma of Pharynx</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO<br>(b)<br>(c) |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><u>Immediate</u><br><u>?Duration</u>   |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                   |
| 20c. TIME OF INJURY<br>Hour a.m. <u>19</u> p.m. <u>19</u>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-3</u> , 19 <u>67</u> , to <u>1-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-12</u> , 19 <u>67</u> , and that death occurred at <u>4:12</u> M. from the causes and on the date stated above.                                  |                                  | 22a. SIGNATURE<br><u>DAVID F. FAIRBANKS</u><br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |                                   |
| 22b. DATE SIGNED<br><u>6 JAN 67</u>   |                                  | 22c. ADDRESS<br><u>60MC No. Charles Baltimore</u>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>1/12/67</u>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Calvary Cem</u>  |                                  | 23d. LOCATION (City, town or county) (State)<br><u>Anne Arundel Cty. Md.</u>   |                                   |
| 24. FUNERAL DIRECTOR<br><u>Wm. C. March</u><br>ADDRESS<br><u>928 E. North Ave</u>   |                                  | 25a. REC'D BY REGISTRAR<br><u>J. H. Jones</u><br>DATE<br><u>JAN 10 1967</u>  |                                   |
| 25b. REGISTRAR'S SIGNATURE  |                                  |  |                                   |

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00395

## CERTIFICATE OF DEATH

00398

|  |  |  |   |
|--|--|--|---|
| <b>1 PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | <b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |  | c. LENGTH OF STAY IN 1b<br><u>Baltimore 21234</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>St. Joseph Hospital</u>   |  | d. STREET ADDRESS<br><u>2527 Taylor Ave.</u>   |   |
| <b>3. NAME OF DECEASED</b><br>(Type or print) First Middle Last<br><u>Hans A. W. Quade</u>   |  | <b>4. DATE OF DEATH</b><br>Month Day Year<br><u>January 8 19 67</u>  |   |
| <b>5 SEX</b><br><u>male</u>  | <b>6. COLOR OR RACE</b><br><u>white</u>  | <b>7 MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br><u>7-2-1900</u>                                    |
| <b>9. AGE</b> (In years last birthday)<br><u>66 yrs.</u>   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life even retired)<br><u>Retired Jeweler</u>  |   |
| <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><u>Germany</u>   |  | <b>11. BIRTHPLACE</b> (County & State, or foreign country)<br><u>USA</u>   |   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  | <b>13. FATHER'S NAME</b><br><u>William Quade</u>   |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><u>Helen Kleist</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |   |
| <b>16. SOCIAL SECURITY NO.</b><br><u>214011675</u>   |  | <b>17. INFORMANT</b><br><u>Anna Quade</u> Address <u>same</u>  |   |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Tuberculosis of left upper lobe.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO (b) _____<br>} DUE TO (c) _____                                    |  |  |   |
| <b>19. INTERVAL BETWEEN ONSET AND DEATH</b><br><u>0021</u>   |  |  |   |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b><br><u>Carcinoma of rectum.</u>  |  |  |   |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/><br><b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b><br>(If either, NOTIFY MEDICAL EXAMINER)  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)   |   |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  | <b>20f. (City or town) (County) (State)</b>                                   |
| <b>21. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>January 6, 19 67</u> to <u>January 8, 19 67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>January 8, 19 67</u> , and that death occurred at <u>5:35 PM</u> from causes and on the date stated above. |  |  |   |
| <b>22a. SIGNATURE</b><br><u>M.D. Cockburn M.D.</u>   |  | <b>22b. DATE SIGNED</b><br><u>January 9, 1967</u>  |   |
| <b>22c. PHYSICIAN'S NAME (Type)</b><br><u>M.S. Cockburn, M.D.</u>  |  | <b>22d. ADDRESS</b><br><u>7620 York Rd. Baltimore, Md. 21204</u>   |   |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>Burial</u>  | <b>23b. DATE THEREOF</b><br><u>1-11-67</u>   | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Moreland Mem. Park</u>   | <b>23d. LOCATION (City or Town) (County) (State)</b><br><u>Baltimore, Md.</u> |
| <b>24. FUNERAL DIRECTOR</b><br><u>Leonard J. Ruck Inc Baltimore, Md.</u>   |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>JAN 10 1967</u>  |   |
| <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |  | <b>25c. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





## CERTIFICATE OF DEATH

00399

00396

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>P</u>                          |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |  | c. LENGTH OF STAY IN 1b   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ridgeway Manor Nursing Home</u>   |  | d. STREET ADDRESS <u>7407 Kalton Court #8</u>   |  |
| 3 NAME OF DECEASED (Type or print) <u>Albert I. Rankin</u>  |  | 4 DATE OF DEATH <u>January 16, 1967</u>   |  |
| 5. SEX <u>Male</u>  | 6. COLOR OR RACE <u>White</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1897</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Executive</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>Co. Lasting Products</u>   |  |
| 11. BIRTHPLACE (County & State or foreign country) <u>Russia</u>  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |
| 13. FATHER'S NAME <u>Mendel Rankin</u>  |  | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. I</u>  |  | 16. SOCIAL SECURITY NO. <u>216-09-7570</u>  |  |
| 17. INFORMANT <u>Mr. Martin Rankin, 7429 Kalton Court #8</u>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  | INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Progressive Cerebral degeneration</u>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                     |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1 Jan</u> , 19 <u>67</u> , to <u>16 Jan</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>16 Jan</u> 19 <u>67</u> , and that death occurred at <u>8 P.</u> M, from causes and on the date stated above.     |  |   |  |
| 22a. SIGNATURE <u>William Goodman</u> M.D.  |  | 22b. DATE SIGNED <u>17 Jan 67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>Dr. William Goodman</u>   |  | 22d. ADDRESS <u>1345 Sulphur Springs Road</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   | 23b. DATE THEREOF <u>1/18/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY <u>Noses Montifiore</u>  | 23d. LOCAT ON (City or town) (County) (State) <u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>   |  | 25a. REC'D BY REGISTRAR <u>JAN 23 1967</u>  |  |
| 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>   |  | DATE  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

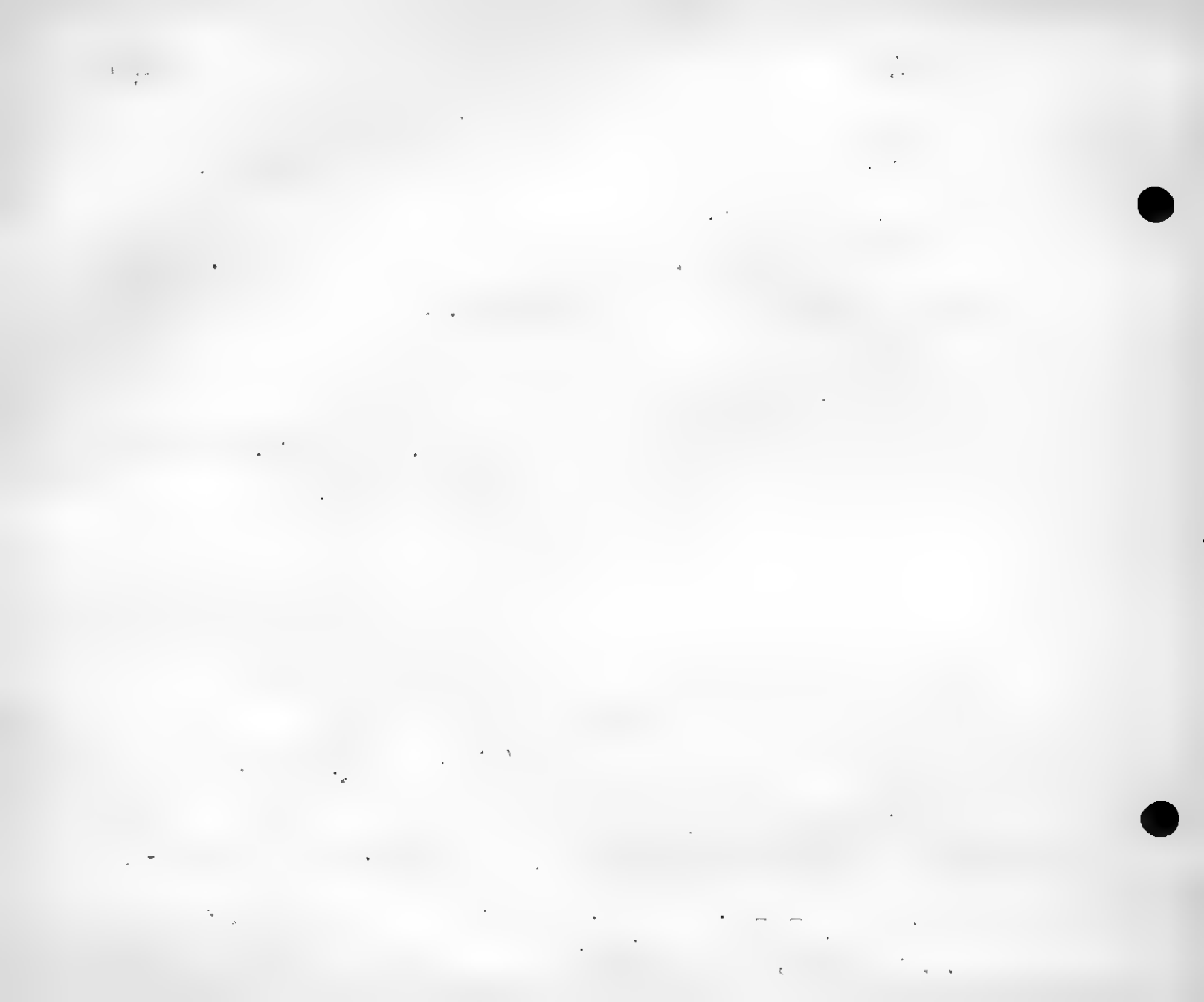
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
|---|--|---------------------------------------|--|---|---|--|---|---|------------------------------|--|--|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
| 00397   |  |                                       |  |   | CERTIFICATE OF DEATH  |  |   |   |                              | 00400  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Ridgeway Manor Nursing Home</b>  |  |                                       |  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>Howard</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Elkridge Route 4</b><br>d. STREET ADDRESS<br><b>Box 284 A</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |                              |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>BESSIE D. RAY</b>  |  |                                       |  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>14</b> Year <b>1967</b>  |  |   |   |                              |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b>      |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>Sept. 1, 1880</b>                               |   | 9. AGE (In years last birthday)<br><b>86</b> yrs. |                              | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min. |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>At Home</b>   |  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY      |   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |   |   | 12. CITIZEN OF WHAT COUNTRY? |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Arthur Chenoweth</b>  |  |                                       |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Swartz</b>   |  |   |   |                              |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>  |  |                                       | 16. SOCIAL SECURITY NO.<br><b>None</b> |   | 17. INFORMANT<br><b>Joseph H. Ray, Monrovia, Md</b>   |  |   | Address<br><b>21770</b>                           |                              |  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b><br>351A DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                                       |  |   |   |  |   |   |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>           |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b><br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>9 Jan</b> , 19 <b>67</b> , to <b>14 Jan</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>13 Jan</b> , 19 <b>67</b> , and that death occurred at <b>12:55 PM</b> , from the causes and on the date stated above.  |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
| 22a. SIGNATURE<br><b>William Goodman, M.D.</b><br>22b. DATE SIGNED<br><b>16 Jan 67</b><br>22c. PHYSICIAN'S NAME (Type)<br><b>WILLIAM GOODMAN, M.D.</b><br>22d. ADDRESS<br><b>1334 Leland Avenue, Baltimore 21221</b>  |  |                                       |  |   |   |  |   |   |                              |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>1-17-1967</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Prospect Hill</b>  |   |  | 23d. LOCATION (City, town or county) (State)<br><b>Towson, Md</b> |   |                              |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>F.C. Higinbotham, Ellicott City, Md</b>  |  |                                       |  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 18 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles J. J...</b>              |   |                              |  |  |  |  |  |



00398

CERTIFICATE OF DEATH

00401

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                                  |  |                                    |  |   |
|--|----------------------------------|--|------------------------------------|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>  |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>Maryland</b>   |                                    | b. COUNTY<br><b>Baltimore</b>  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Rural Baltimore</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>8 1/2 years</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol, give street address)<br><b>Augsburg Lutheran Home<br/>6811 Campfield Road 21207</b>   |                                  | d. STREET ADDRESS<br><b>3820 Parkmont Avenue</b>   |                                    | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |   |
| 3. NAME OF DECEASED (Type or print)<br><b>Mary Elizabeth Richard</b>   |                                  | 4. DATE OF DEATH<br><b>January 7 19 67</b>   |                                    |  |   |
| 5 SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>3/17/88</b> | 9 AGE (In years last birthday)<br><b>78 yrs.</b>   | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work, no life, even if retired)<br><b>Housework</b>   |                                  | 10a. KIND OF BUSINESS OR INDUSTRY  |                                    | 11 BIRTHPLACE (County & State or foreign country)<br><b>Baltimore, Maryland</b>                      |   |
| 13. FATHER'S NAME<br><b>John Bloberger</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Meta Margaret Pestrup</b>   |                                    | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO<br><b>218-34-1635A</b>  |                                    | 17. INFORMANT<br><b>Paul A. Hauer 6811 Campfield Road 21207</b>                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY.<br><b>4200</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease with Fibrillation</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>(c) |                                  |  |                                    |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 yrs</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Generalized Arteriosclerosis</b>  |                                  |  |                                    |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |                                    |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work   |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                               |   |
| 20f. (City or town)  |                                  | (County)   |                                    | (State)  |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> , 19 <b>to Jan - 7</b> , 1967, that (I) ( <del>was</del> ) saw the deceased alive on <b>Jan. 5 - 1967</b> , and that death occurred at <b>5P</b> M, from causes and on the date stated above.  |                                  |  |                                    |  |   |
| 22a. SIGNATURE<br><b>Earl L. Chambers</b>  |                                  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                       |                                    | 22b. DATE SIGNED<br><b>1/7/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Earl L. Chambers</b>  |                                  | 22d. ADDRESS<br><b>4108 Liberty St. Baltimore Md</b>   |                                    |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/10/67</b>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gradyn Park</b>   |   |
| 23d. LOCATION (City or town)<br><b>Baltimore</b>   |                                  | (County)   |                                    | (State)  |   |
| 24. FUNERAL DIRECTOR<br><b>W. Deemann 6667 Hay Rd</b>  |                                  | ADDRESS  |                                    | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1967</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |                                  |  |                                    |  |   |



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 13. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

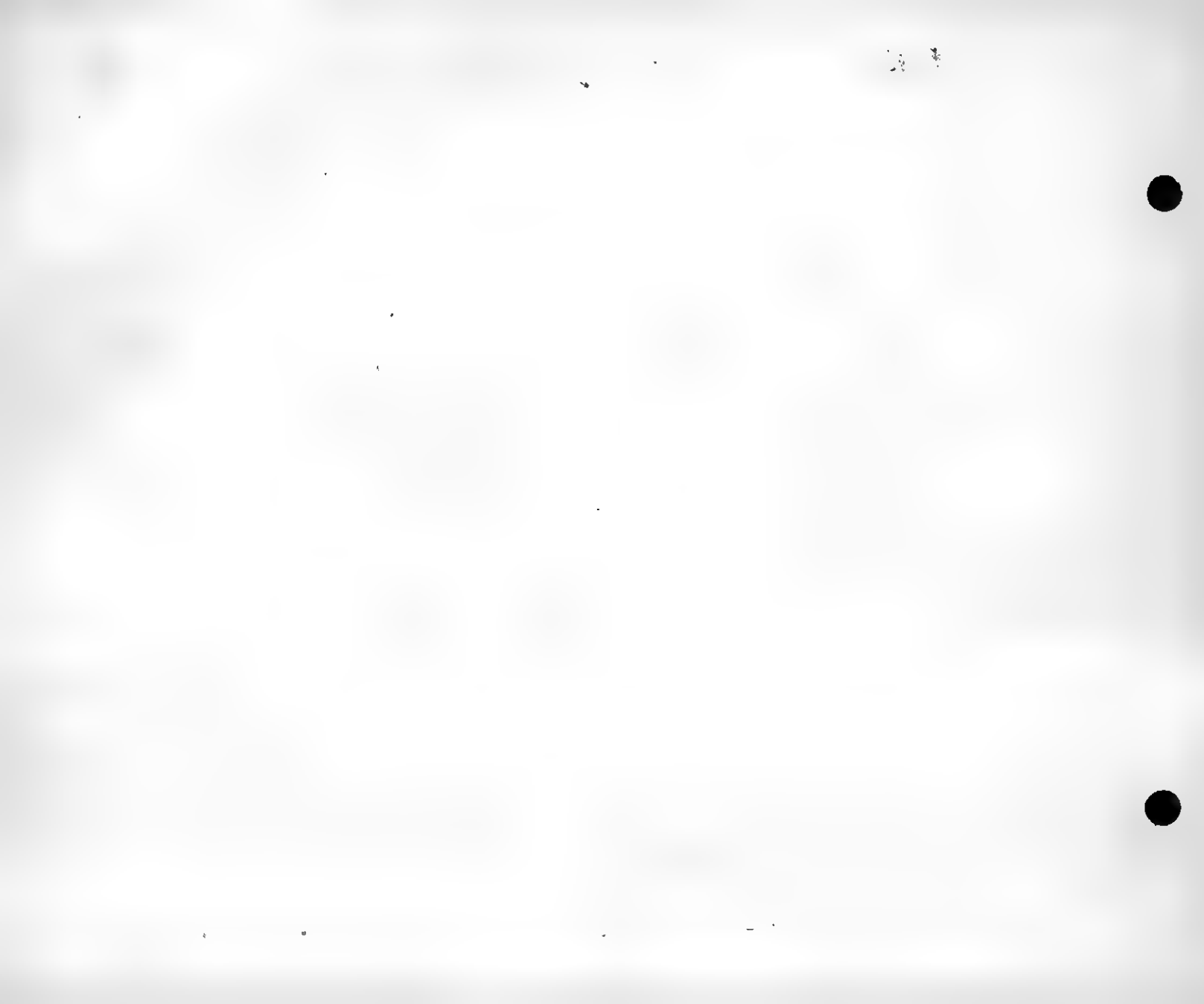
00399

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00402

|  |  |  |                          |   |  |  |  |
|--|--|--|--------------------------|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |  |                          | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓               |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore Rural</b>   |  |  | c. LENGTH OF STAY IN - b |   | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Baltimore Rural 13.1</b> |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>200 Fleming Drive</b>   |  |  |                          | d. STREET ADDRESS<br><b>200 Fleming Drive</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>RONALD KEITH RICHARDSON</b>   |  |  |                          | 4. DATE OF DEATH<br>Month Day Year<br><b>January 23 19 67</b>   |  |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>Negro</b>   |                          | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>Nov. 26, 1966</b>   |  |
| 9. AGE (In years last birthday) yrs<br><b>1</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Infant</b> |                          | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto., Md.</b>                        |  |
| 13. FATHER'S NAME<br><b>Harold Ramsome</b>   |  |  |                          | 14. MOTHER'S MAIDEN NAME<br><b>Theresa Richardson</b>   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  | 16. SOCIAL SECURITY NO   |                          | 17. INFORMANT<br>Address<br><b>Mr. Leon Richardson 200 Fleming Drive</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Interstitial Pneumonitis.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost<br>(b)<br>DUE TO<br>(c)  |  |  |                          |   |  |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)   |  |  |                          |   |  |  | 9. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS<br>PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)                   |                          |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>    |                          | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |  |  |                          |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Charles S. Petty</i>  |  | M.D.<br>EXAMINER'S NAME (Type)<br><b>Charles S. Petty</b>  |                          |   |  | 22. DATE SIGNED<br><b>1/24/67</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 23b. DATE THEREOF<br><b>1-25-67</b>  |                          | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary Cem.</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>A.A. Co., Md.</b>                  |  |
| 24. FUNERAL DIRECTOR<br><b>Morton &amp; Dyett F.H.</b>   |  |  |                          | 25. REC'D BY REGISTRAR<br><b>1701 Laurens Str.</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>                                     |  |

DATE **JAN 26 1967**





00400

## CERTIFICATE OF DEATH

00403

|  |                                  |  |  |
|--|----------------------------------|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>               |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>34 yrs</b>   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Shady Nook Nursing &amp; Convalescent Home</b>  |                                  | d. STREET ADDRESS<br><b>218 Newburg Avenue</b>   |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>HARVEY HERSHEY RIDDLE</b>  |                                  | 4. DATE OF DEATH<br><b>Jan. 3, 1967</b>  |  |
| 5 SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 7, 1889</b>  |
| 9. AGE (In years last birthday)<br><b>77 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Carpenter</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Employed by Builders</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore Co., Md.</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Edwin Riddle</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Erene Hershey</b>  |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>216-07-8838 A</b>   |  |
| 17. INFORMANT<br><b>Mrs. Thomas Lawrence</b>   |                                  | Address <b>21228 218 E. Newburg Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic cardiac decompensation</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Hypertensive arteriosclerotic cardiovascular disease</b><br>DUE TO<br>(c) <b>5 yrs.</b> |                                  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 months</b>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |  |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                                  | 20f. (City or town) (County) (State)   |  |
| 21 I certify that (I) (this hospital) attended the deceased from <b>May 25, 1961</b> , to <b>Jan 3, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 2, 1967</b> , and that death occurred at <b>4:30 A.M.</b> from causes and on the date stated above.   |                                  |  |  |
| 22a. SIGNATURE<br><b>John A. Nesbitt Jr.</b>   |                                  | 22b. DATE SIGNED<br><b>1-4-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>John A. Nesbitt Jr. M.D.</b>  |                                  | 22d. ADDRESS<br><b>1009 Frederick Rd. Catonsville, 28, Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/5/1967</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Johns Cemetery</b>  |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Ellicott City Howard Co., Md.</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Easton Funeral Home</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  | DATE<br><b>JAN 5 1967</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When page 3 is removed, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00401

## CERTIFICATE OF DEATH

00404

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |  |  |
|---|--|--|--|
| <b>1 PLACE OF DEATH</b><br>a. COUNTY <u>BALTO.</u> MARYLAND<br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WHITE MARSH</u><br>c. LENGTH OF STAY IN 1b<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>RTE 1 BOX 118 VINCENT RD</u>   |  | <b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution on Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>WHITE MARSH 1-1</u><br>d. STREET ADDRESS<br><u>RTE 1 BOX 118 VINCENT RD</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| <b>3 NAME OF DECEASED</b> (Type or print) <u>ELLA MERA RIFFLE</u><br>First Middle Last<br><b>5 SEX</b> <u>F</u> <b>6 COLOR OR RACE</b> <u>W</u> <b>7 MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>8 DATE OF BIRTH</b> <u>JULY 2 1888</u><br><b>9 AGE</b> (In years last birthday) <u>78</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min. |  | <b>4 DATE OF DEATH</b> <u>JAN 19 1967</u><br>Month Day Year  |  |
| <b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>11 BIRTHPLACE</b> (County & State, or foreign country)<br><u>W. VA.</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>  |  | <b>13. FATHER'S NAME</b><br><u>CONRAD</u><br><b>14. MOTHER'S MAIDEN NAME</b><br><u>?</u>   |  |
| <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates at service)<br><u>NO</u><br><b>16. SOCIAL SECURITY NO</b><br><b>17. INFORMANT</b> <u>LOUIE FOLEY</u> Address <u>ABOVE</u>  |  | <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>443X</u> IMMEDIATE CAUSE (a) <u>Cerebrovascular accident Immediate</u><br>DUE TO (b) <u>Hypertensive arteriosclerotic</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>vascular disease</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>None</u>  |  |
| <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town) (County) (State)</b> |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from Jan 1958, to Jan 19 1967, that (I) (we) last saw the deceased alive on Jan 19 1967, and that death occurred at 1:50 P.M. from causes and on the date stated above.</b>   |  |  |  |
| <b>22a. SIGNATURE</b><br><u>[Signature]</u> M.D.<br><b>22c. PHYSICIAN'S NAME (Type)</b><br><b>22d. ADDRESS</b>  |  | <b>22b. DATE SIGNED</b><br><u>1-20-67</u><br><b>22e. ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS</b> <input checked="" type="checkbox"/>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><u>BURIAL</u><br><b>23b. DATE THEREOF</b><br><u>1/23/67</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>CHURCH LANE</u><br><b>23d. LOCATION (City or Town) (County) (State)</b><br><u>BALTO MD.</u>  |  | <b>25a. REC'D BY REGISTRAR</b><br>DATE <u>JAN 24 1967</u><br><b>25b. REGISTRAR'S SIGNATURE</b><br><u>[Signature]</u>   |  |
| <b>24. FUNERAL DIRECTOR</b><br><u>J. C. CONNELLY SONS</u><br>ADDRESS <u>300 MACE</u>  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |  |  |  |   |  |   |   |   |  |  |
|--|--|--|--|--|---|--|---|---|---|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |   |   |   |  |  |
| 00402  |  |  |  |  | 00405   |  |   |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>c. LENGTH OF STAY IN 1b <u>1 hr.</u>   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>10708 Tyne Ave</u> |  |   |   |   |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>   |  |  |  |  | d. STREET ADDRESS <u>10708 Tyne Ave</u>   |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><u>NORRIS ROBERT RILEY</u>  |  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>Jan. 4 1967</u>   |  | 5. SEX <u>Male</u><br>6. COLOR OR RACE <u>Cau.</u><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   |   |   |  |  |
| 8. DATE OF BIRTH<br><u>10-4-92</u>   |  |  | 9. AGE (in years last birthday) <u>74</u> yrs.   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cabinetmaker-Ret.</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u> |   | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |  |  |
| 13. FATHER'S NAME<br><u>JOSHUA RILEY</u>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>MARGARET LEESE</u>   |  |   |   |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWI WWI</u>   |  |  | 16. SOCIAL SECURITY NO. <u>212-01-1547</u>   |  | 17. INFORMANT<br>Address<br><u>Wife</u>   |  |   |   |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>4201<br>DUE TO (b) <u>Arterio-sclerotic vasculon</u><br>DUE TO (c) <u>disease.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |  |   |  |   |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  |  |   |  |   |   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  |  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not while <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)                                      |   |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 4</u> , 19 <u>67</u> to <u>Jan 4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan 4</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.  |  |  |  |  |   |  |   |   |   |  |  |
| 22a. SIGNATURE<br><u>M. I. MacGregor</u>   |  |  |  |  | 22b. DATE SIGNED  |  | 22c. PHYSICIAN'S NAME (Type) <u>1. Mac GREGOR.</u>                        |   |   |  |  |
| 22d. ADDRESS<br><u>Greater Baltimore Medical Center</u>  |  |  |  |  | 22e. REC'D BY REGISTRAR   |  |   |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  |  | 23b. DATE THEREOF <u>JAN. 7, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>POPLAR GROVE CEM.</u>   |  | 23d. LOCATION (City, town or county) (State) <u>COCKEYSVILLE, MD.</u>     |   |   |  |  |
| 24. FUNERAL DIRECTOR<br><u>John Sammons</u>  |  |  |  |  | 25a. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |  |   |   |   |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

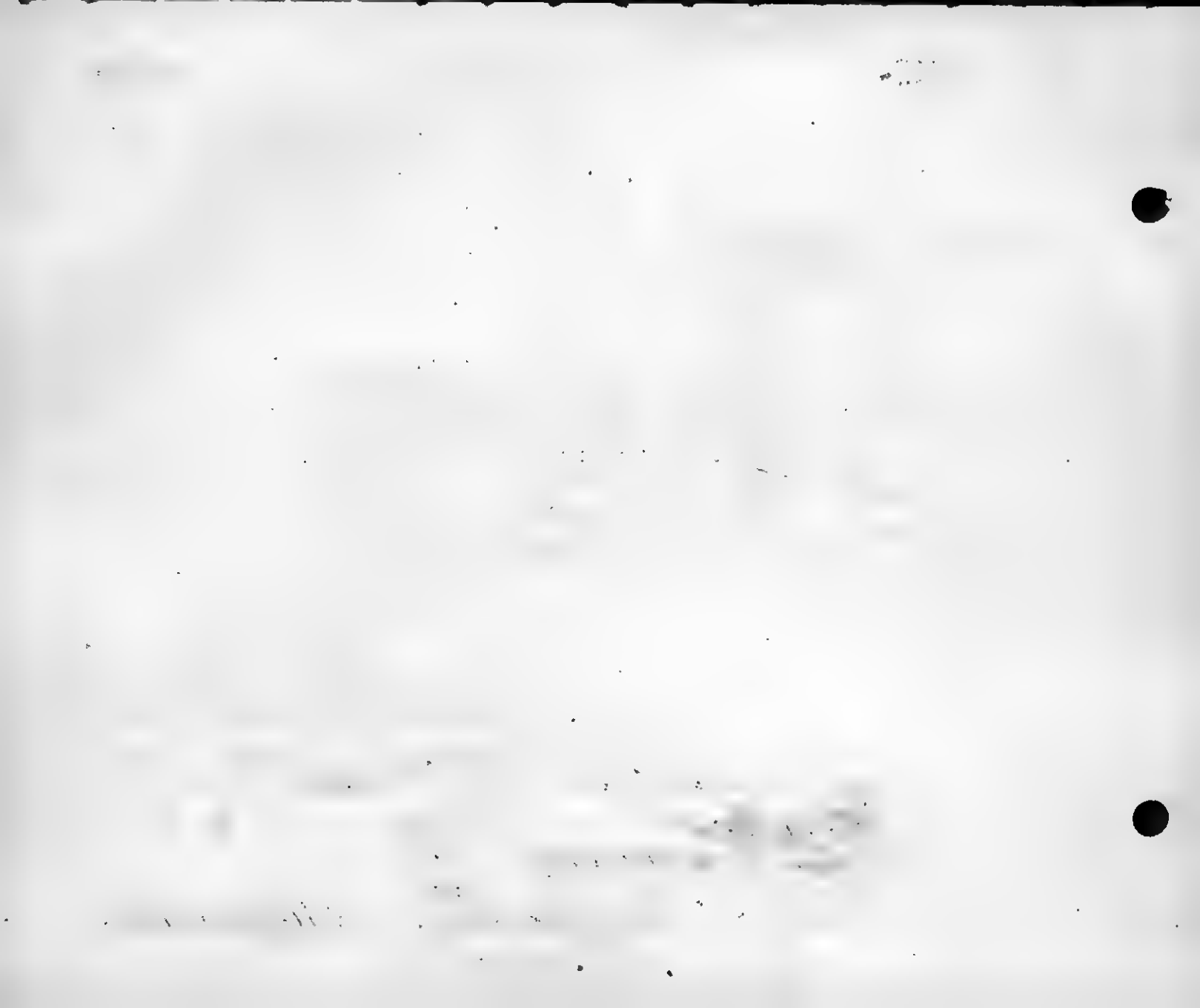
(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00403

00406

|  |  |   |  |  |  |  |  |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>                |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK MD.</u>  |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> <u>21222</u>   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTO. MED. CENTER</u>   |  |   |  | d. STREET ADDRESS <u>2954 Sollers Pl. Rd.</u>  |  |  |  |
| 3. NAME OF DECEASED (Type or print) First <u>JACOB</u> Middle <u>RAYMOND</u> Last <u>RITZMAN</u>   |  |   |  | 4. DATE OF DEATH Month <u>JAN.</u> Day <u>5</u> Year <u>1967</u>   |  |  |  |
| 5. SEX <u>M</u>  |  | 6. COLOR OR RACE <u>WHITE</u>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>11/27/15</u>   |  |
| 9. AGE (In years last birthday) <u>51</u> yrs.   |  | IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>5</u>                                |  | IF UNDER 24 HRS. Months <u>5</u> Days <u>1</u> Hours <u>1</u> Min. <u>5</u>  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INSTALLING</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>STORM WINDOWS</u>   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>SHAMONKIN, PENNA.</u> |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |  |   |  |  |  |  |  |
| 13. FATHER'S NAME <u>JACOB M RITZMAN</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>CARRIE ROSS</u>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>   |  |   |  | 16. SOCIAL SECURITY NO. <u>42-45-210-161-400</u>   |  | 17. INFORMANT <u>PATIENT'S CHART</u> Address                                 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE PERITONITIS</u><br><u>140-18-8287</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERFORATED PEPTIC ULCER, STOMACH</u><br>DUE TO (c) |  |   |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>DAYS</u><br><u>DAYS</u>                                 |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>CARCINOMA OF LUNG WITH METASTASES</u>  |  |   |  |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <u>19</u> a.m. <u>19</u> p.m.   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-5-67</u> , 19 <u>67</u> to <u>1-5-67</u> , 19 <u>67</u> , that (I) <u>two</u> last saw the deceased alive on <u>1-5-67</u> , 19 <u>67</u> , and that death occurred at <u>6:15 PM</u> from the causes and on the date stated above.   |  |   |  |  |  |  |  |
| 22a. SIGNATURE <u>R. Chiller</u>   |  |   |  |  |  | 22b. DATE SIGNED <u>1-5-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHILLAR</u>   |  |   |  | 22d. ADDRESS   |  |  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  | 23b. DATE THEREOF <u>1/9/1967</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>C.O.D.D. FELLOWS</u>   |  | 23d. LOCATION (City, town or county) (State) <u>SHAMONKIN PENNA</u>          |  |
| 24. FUNERAL DIRECTOR <u>Superior Burial, Dundalk, MD</u>   |  |   |  | 25a. REC'D BY REGISTRAR <u>JAN 9 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Wesley Judge</u>                               |  |





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00404

CERTIFICATE OF DEATH

00407

|   |                                       |  |   |
|---|---------------------------------------|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |                                       | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u>               |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>   |                                       | c. LENGTH OF STAY IN 1b <u>4 DAYS</u>  |   |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLLEGE PARK</u>  |                                       | d. STREET ADDRESS <u>9005 48<sup>th</sup> PLACE</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE ST. HOSPITAL</u>   |                                       | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 3. NAME OF DECEASED (Type or print) <u>(H) HELEN</u> First <u>M</u> Middle <u>ROBERTS</u> Last  |                                       | 4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1967</u>   |   |
| 5. SEX <u>F</u>   | 6. COLOR OR RACE <u>W</u>             | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-14-98</u>   |
| 9. AGE (In years last birthday) <u>68</u> yrs   |                                       | IF UNDER 1 YEAR Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>  |                                       | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>  |   |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u>   |                                       | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>  |   |
| 13. FATHER'S NAME <u>HOWARD MARSHALL</u>  |                                       | 14. MOTHER'S MAIDEN NAME <u>ESTELLA CURTIS</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>   |                                       | 16. SOCIAL SECURITY NO. <u>219-54-9826</u>   |   |
| 17. INFORMANT <u>HOSPITAL RECORDS</u>   |                                       | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u><br><u>420.1</u> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO<br>(c) _____<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>DIABETES MELLITUS</u> |                                       |  |   |
| 19. WAS A JIOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                       |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                       | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |                                       | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                       | 20f. (City or town) (County) (State)   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-9</u> , 19 <u>67</u> to <u>1-13</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-13</u> , 19 <u>67</u> , and that death occurred at <u>7:20</u> PM, from causes and on the date stated above.  |                                       |  |   |
| 22a. SIGNATURE <u>Rolando Vieta</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |                                       | 22b. DATE SIGNED <u>1-13-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type) <u>ROLANDO VIETA</u>   |                                       | 22d. ADDRESS <u>SPRING GROVE ST. HOSPITAL</u>  |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  | 23b. DATE THEREOF <u>Jan 17, 1967</u> | 23c. NAME OF CEMETERY OR CREMATOR <u>Ft Lincoln Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Geo Md.</u> |
| 24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> ADDRESS <u>Hyattsville, Md.</u>   |                                       | 25a. REC'D BY REGISTRAR <u>JAN 16 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00405

## CERTIFICATE OF DEATH

00408

|   |   |   |   |
|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>452 Main Street</b>  |   | d. STREET ADDRESS<br><b>452 Main Street</b>   |   |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Max</b> Middle <b>L.</b> Last <b>Robertson</b>   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>10</b> Year <b>19 67</b>  |   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 17, 1885</b>  |
| 9. AGE (In years last birthday)<br><b>81</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months <b>10</b> Days <b>19</b> Hours <b>67</b> Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Builder</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>James A. Robertson</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>James A. Shelton</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |   | 16. SOCIAL SECURITY NO.<br><b>218-32-1197</b>   |   |
| 17. INFORMANT<br><b>Mrs. Martha E. Robertson</b>  |   | Address<br><b>Reisterstown, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocarditis - Chronic</b><br>442X DUE TO <b>decompensation</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b><br>DUE TO <b>arteriosclerotic disease</b><br>(c) <b>asphyxia</b> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b><br><b>10 yrs</b><br><b>years</b>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1-1-1967</b> to <b>1-10-1967</b> , that (I) (we) last saw the deceased alive on <b>1-1-1967</b> , and that death occurred at <b>10:30</b> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>James G. Saffell</b>   |   | 22b. DATE SIGNED<br><b>1-11-67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>James G. Saffell MD</b>  |   | 22d. ADDRESS<br><b>Reisterstown, Md.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/13, 67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Pikesville, Md.</b>                           |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons</b>   |   | 25a. REC'D BY REGISTRAR<br><b>Charles Judge</b>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>J. F. Eline &amp; Sons</b>   |   | DATE <b>JAN 13 1967</b>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.)



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00406

## CERTIFICATE OF DEATH

00409

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |                               |  |                                       |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Bladensburg</u>           |                                       |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bladensburg</u>   |                               | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Bladensburg</u>   |                                       |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Bladensburg</u>   |                               | d. STREET ADDRESS<br><u>5027 57th Avenue</u>   |                                       |
| 3. NAME OF DECEASED<br>(Type or print) First <u>Frederic</u> Middle <u>Line</u> Last <u>Roeder</u>   |                               | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>5</u> Year <u>1967</u>   |                                       |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-25-1902</u> |
| 9. AGE (In years last birthday) yrs. <u>4</u>  |                               | 10. IF UNDER 1 YEAR<br>Months <u>2</u> Days <u>19</u> Hours <u>67</u> Min.   |                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>   |                                       |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>Washington, D.C.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                                       |
| 13. FATHER'S NAME<br><u>Lindwood T Roeder</u>  |                               | 14. MOTHER'S MAIDEN NAME<br><u>M. Price</u>  |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>   |                               | 16. SOCIAL SECURITY NO<br><u>none</u>  |                                       |
| 17. INFORMANT<br><u>Charles Judge</u>  |                               | Address<br><u>Bladensburg, Md.</u>   |                                       |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Shigellosis with hemorrhagic diarrhea</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>  </u><br>DUE TO<br>(c) <u>  </u> |                               | INTERVAL BETWEEN ONSET AND DEATH<br><u>28 days</u>   |                                       |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Institutionalized by State in 1966</u>  |                               | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                       |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                       |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u>  </u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                       |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                               | 20f. (City or town) (County) (State)   |                                       |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-1-67</u> to <u>1-5-67</u> , 19 <u>67</u> ; that (I) <u>(we)</u> last saw the deceased alive on <u>1-4-67</u> , 19 <u>67</u> , and that death occurred at <u>1:45</u> M, from causes and on the date stated above.   |                               |  |                                       |
| 22a. SIGNATURE<br><u>Richard E. Jones</u> M.D.   |                               | 22b. DATE SIGNED<br><u>3 Jan 1967</u>  |                                       |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Dr. Richard E. Jones</u>  |                               | 22d. ADDRESS<br><u>3011 County General Hospital</u>  |                                       |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                               | 23b. DATE THEREOF<br><u>1/5/67</u>   |                                       |
| 23c. NAME OF CEMETERY OR CREMATORY<br><u>Ft. Lincoln</u>   |                               | 23d. LOCATION (City or Town) (County) (State)<br><u>Colmar Manor P.G. Md.</u>  |                                       |
| 24. FUNERAL DIRECTOR<br><u>Francis Gasch's Sons Hyattsville, Md.</u>   |                               | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 5 1967</u>  |                                       |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |                               |  |                                       |



00407

## CERTIFICATE OF DEATH

00410

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |   |  |
|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTO. CO.</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>MD.</u> b. COUNTY                                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>CATONSVILLE</u>   |  | c. LENGTH OF STAY IN 1b<br><u>CATONSVILLE</u>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>SHANGRI-LA HOME</u>   |  | d. STREET ADDRESS<br><u>701 DORCHESTER RD.</u>  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>FLORA B. ROGERS</u>  |  | 4. DATE OF DEATH<br>Month <u>11</u> Day <u>6</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>F</u>   | 6. COLOR OR RACE<br><u>W</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>3/7/72</u>                                      |
| 9. AGE (In years last birthday)<br><u>94</u> yrs.  |  | 10. F UNDER 1 YEAR<br>Months <u>11</u> Days <u>6</u> Hours <u>19</u> Min  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>  |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>NORTH CAROLINA</u>  |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><u>EDW. WALKER</u>  |  | 14. MOTHER'S MAIDEN NAME<br><u>DOROTHY HAWKINS</u>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><u>WILMA NOTT</u>   |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>Congestive heart failure.</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>ASCVD</u><br>DUE TO<br>(c) |  |   |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>Pneumonia</u>  |  |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>9/1</u> , 19 <u>65</u> , to <u>1/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/6</u> , 19 <u>67</u> , and that death occurred at <u>1P</u> M, from causes on and the date stated above                           |  |   |  |
| 22a. SIGNATURE<br><u>James E. Rowe</u>   |  | 22b. DATE SIGNED<br><u>1/7/67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>JAMES E. ROWE</u>   |  | 22d. ADDRESS<br><u>CATONSVILLE, MD.</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1/9/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>CHRIST CHURCH</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>HOWARD CO. MD.</u> |
| 24. FUNERAL DIRECTOR<br><u>E.S. MALNABB</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 9 1967</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |  |   |  |





00408

CERTIFICATE OF DEATH

00411

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RANDALLSTOWN</u>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RANDALLSTOWN</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>8722 Church Lane</u>   |  | e. STREET ADDRESS<br><u>8722 Church Lane</u>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><u>KATHERINE (KATE) ROGERS</u>  |  | 4. DATE OF DEATH<br>Month Day Year<br><u>JAN. 16, 1967</u>  |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>C</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>APRIL 8, 1880</u>  |
| 9. AGE (in years last birthday)<br><u>86 yrs</u>  |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 11b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>MARYLAND</u>  |  | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 13. FATHER'S NAME<br><u>WILLIAM GHENT</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>ELIZABETH HARDEN</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  | 16. SOCIAL SECURITY NO  |   |
| 17. INFORMANT<br><u>LILLIAN DORSEY</u>  |  | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerotic Heart Failure</u><br>DUE TO (b) <u>Myocardial Infarction</u><br>DUE TO (c) <u>Hypertension</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>3 days</u><br><u>10 days</u>              |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br>19  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) <del>(was hospital)</del> attended the deceased from <u>11/14, 1967</u> to <u>1/16, 1967</u> , that (I) <del>(we)</del> lost saw the deceased alive on <u>1/15, 1967</u> , and that death occurred at <u>10:30 A.M.</u> , from causes and on the date stated above   |  |   |   |
| 22a. SIGNATURE<br><u>Edwin L. Pierport, M.D.</u>  |  | 22b. DATE SIGNED<br><u>1/16/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>EDWIN L. PIERPORT, M.D.</u>  |  | 22d. ADDRESS<br><u>8214 LIBERTY AVE. BALTO., MD 21207</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>1/19/67</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ST THOMAS</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>RANDALLSTOWN MD</u>                           |
| 24. FUNERAL DIRECTOR<br><u>WILLIAM MARCH 928 E. NORTH AVE</u>   |  | 25a. REC'D BY REGISTRAR<br><u>DATE JAN 20 1967</u>  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (See page 1 and 2 of instructions.) This page should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



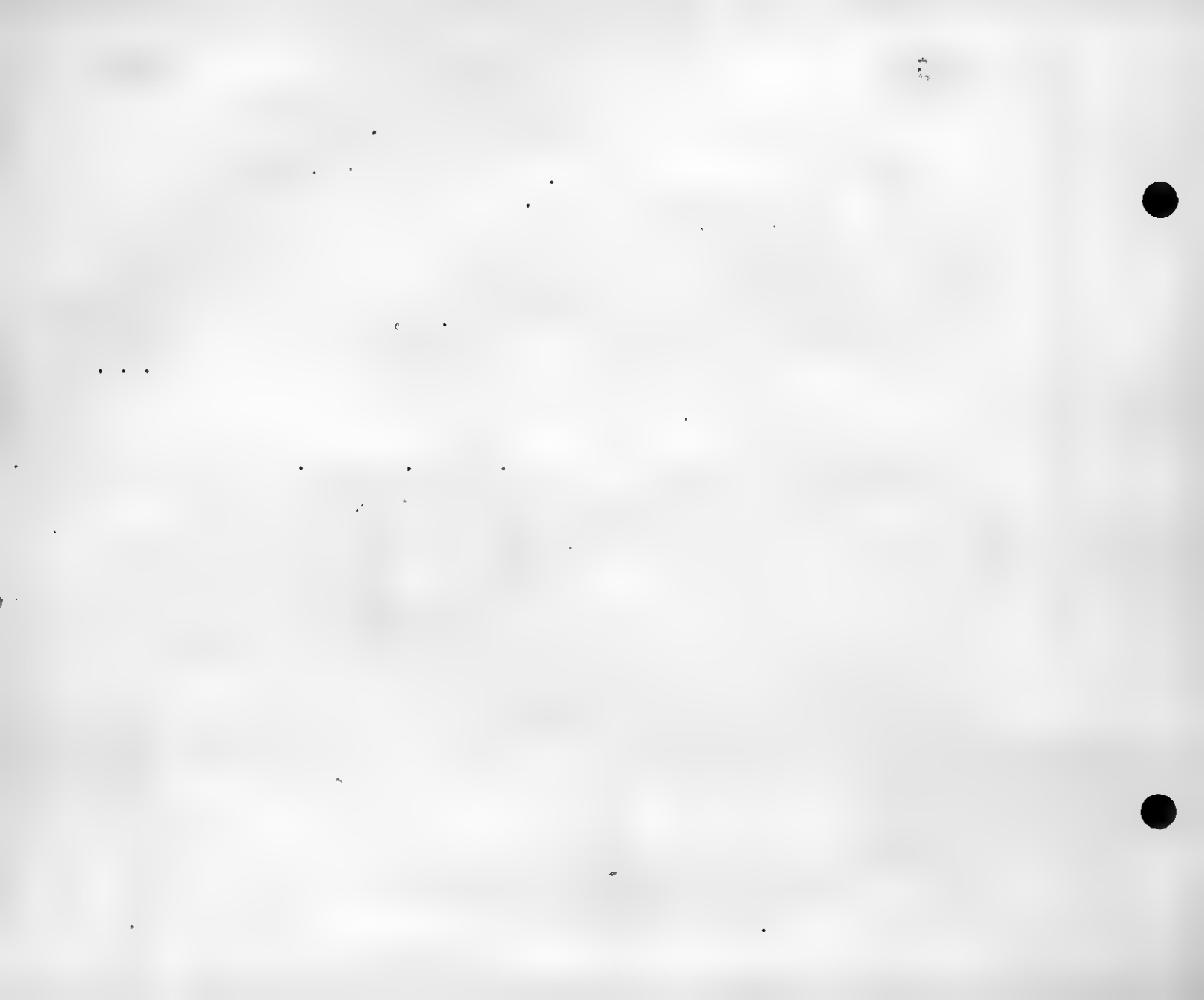
00409

CERTIFICATE OF DEATH

00412

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then the funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body. If at any event, within 72 hours after death should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body.

|   |                                  |   |  |   |  |   |   |
|---|----------------------------------|---|--|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u> |  |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randallstown</u>   |                                  | c. LENGTH OF STAY IN 1b<br><u>6 wks.</u>  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Pikesville 8,</u>                                |  |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md.</u><br><u>Chapel Hill Nursing Home, Randallstown</u>  |                                  |   |  | d. STREET ADDRESS<br><u>10 Cliveden Road</u>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>Alexander</u> First <u>Romans</u> Middle <u>Romans</u> Last   |                                  |   |  | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>30</u> Year <u>1967</u>   |  |   |   |
| 5. SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u> | 7. MARRIED<br><input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>Sept. 15, 1881</u>                              | 9. AGE (In years last birthday)<br><u>85</u> yrs  | 10. IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. |   | 11. IF UNDER 24 HRS.<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.                         |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired</u>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Contractor-self</u>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13. FATHER'S NAME<br><u>WILLIAM ROMANS</u>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>BETTIE SCOTT</u>   |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>   |                                  | 16. SOCIAL SECURITY NO.<br><u>unknown</u>   |  | 17. INFORMANT<br><u>Mr. Harry H. Keels, P.O. Box 87, Glen Burnie, Md.</u>   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia - Lobar</u><br>DUE TO (b) <u>Myocarditis - decompensating</u><br>DUE TO (c) <u>Hypertension - Generalized arteriosclerotic disease</u>        |                                  |   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u><br><u>month</u><br><u>year</u>                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                  |   |  |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>✓</u> 19 <u>67</u><br>p.m.   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work of work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)                                     |   |   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-10</u> , 19 <u>66</u> to <u>1-30</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-30</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above. |                                  |   |  |   |  |   |   |
| 22a. SIGNATURE<br><u>James G. Saffell</u>   |                                  |   |  | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>    |  | 22b. DATE SIGNED<br><u>1-31-67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>James G. Saffell M.D.</u>  |                                  |   |  | 22d. ADDRESS<br><u>Reisterstown, Md.</u>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                                  | 23b. DATE THEREOF<br><u>Feb. 2, 1967</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Druid Ridge Cemetery</u>   |  | 23d. LOCATION (City or Town) (County) (State)<br><u>Pikesville 8, Md.</u>                         |   |
| 24. FUNERAL DIRECTOR<br><u>Frank H. Howard</u>  |                                  |   |  | 25a. REC'D BY REGISTRAR<br>DATE <u>FEB 3 1967</u>   |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |



00410

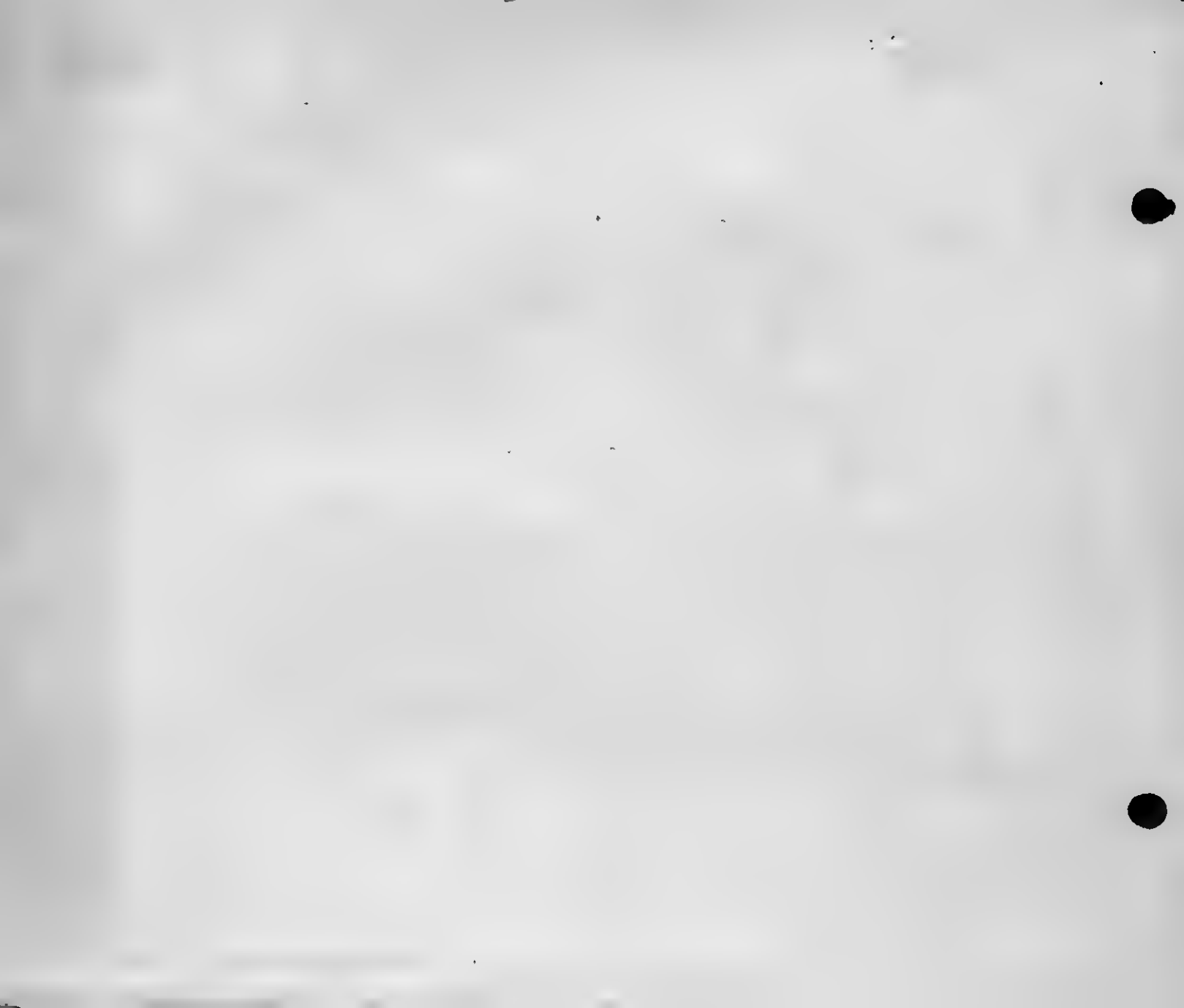
CERTIFICATE OF DEATH

00413

|  |  |   |  |  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> <u>MARYLAND</u><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u><br>c. LENGTH OF STAY IN b. <u>Professional House, Inc.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)   |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>3813 Menlo Drive</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Miriam</u> <u>Rosenfeld</u><br>First Middle Last<br>4. DATE OF DEATH <u>1</u> <u>10</u> <u>1967</u><br>Month Day Year   |  |   |  | 5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>9/1/71</u><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>95</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.  |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u><br>10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>   |  |   |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>   |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>                                 |  |
| 13. FATHER'S NAME <u>Michael Rosenfeld</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Carolyn Weisenfeld</u>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO. <u>220-44-8362</u>   |  | 17. INFORMANT <u>Mr. Irvin E. Robinson, 3813 Menlo Drive</u><br>Address |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>331X Cerebral Vascular Accident</u><br>Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u><br>(a), stating the underlying cause last. (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) |  |   |  | INTERVAL BETWEEN ONSET AND DEATH <u>hours</u><br><u>unknown</u>  |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                                    |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>10-2</u> , 19 <u>67</u> , to <u>1-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-10</u> , 19 <u>67</u> , and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above.   |  |   |  |  |  |   |  |
| 22a. SIGNATURE <u>David F. Miller</u> M.D.   |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>  |  | 22b. DATE SIGNED <u>1-10-67</u>   |  |
| 22c. PHYSICIAN'S NAME (Type) <u>David F. Miller</u>  |  |   |  | 22d. ADDRESS <u>Lincoln Rd. Owings Mills, Md.</u>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  | 23b. DATE THEREOF <u>1/13/67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levinson &amp; Bros. Inc., 6010 Reist., Rd.</u>  |  |   |  | 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>  |  | 25b. REGISTRAR'S SIGNATURE  |  |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00411

## CERTIFICATE OF DEATH

00414

|   |                              |   |  |
|---|------------------------------|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>   |                              | 2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>DISTRICT OF COLUMBIA</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>  |                              | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 3 NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>VIRGINIA</b> Last <b>ROSS</b>  |                              | 4 DATE OF DEATH Month <b>JANUARY</b> Day <b>11</b> Year <b>19 67</b>  |  |
| 5 SEX <b>FEMALE</b>   | 6 COLOR OR RACE <b>NEGRO</b> | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH <b>AUGUST 30, 1919</b> |
| 9 AGE (n years last birthday) yrs <b>47</b>   |                              | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COOK</b>   |  |
| 10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOL</b>   |                              | 11. BIRTHPLACE (County & State, or foreign country) <b>LEXINGTON, VIRGINIA</b>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |                              | 13. FATHER'S NAME <b>NAME UNKNOWN</b>   |  |
| 14. MOTHER'S MAIDEN NAME <b>CARRIE ROSS</b>   |                              | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>YES PL 28</b>   |  |
| 16. SOCIAL SECURITY NO. <b>227 14 23 02</b>   |                              | 17. INFORMANT Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>RUPTURE OF ANEURYSM OF LEFT VENTRICLE, ACUTE</b><br>DUE TO (b) <b>MYOCARDIAL INFARCTION</b><br>DUE TO (c) <b>ARTERIOSCLEROTIC CORONARY THROMBOSIS</b>  |                              | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b><br><b>RECENT</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                              | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour 'o m. p.m. <b>19</b>   |                              | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) (County) (State)  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/29/66</b> , 19__ to <b>1/11/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/11/67</b> , 19__, and that death occurred at <b>11:50 PM</b> from causes and on the date stated above. |                              |   |  |
| 22a. SIGNATURE <b>George Dudas</b>  |                              | 22b. DATE SIGNED <b>1/12/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type) <b>GEORGE DUDAS, M. D.</b>   |                              | 22d. ADDRESS <b>VAH FORT HOWARD, MARYLAND</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                              | 23b. DATE THEREOF <b>1/16/67</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>BALTIMORE NATIONAL</b>  |                              | 23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE, MARYLAND</b>  |  |
| 24. FUNERAL DIRECTOR <b>Irvin P. Carroll</b>  |                              | 25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>   |                              |   |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |                             |   |                                  |  |   |  |   |  |   |  |
|--|-----------------------------|---|----------------------------------|--|---|--|---|--|---|--|
| 00412  |                             |   |                                  |  | 00415   |  |   |  |   |  |
| 1. PLACE OF DEATH  |                             |   |                                  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)             |  |   |  |   |  |
| a. COUNTY <u>Baltimore</u> MARYLAND  |                             |   |                                  |  | a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>  |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Rural)</u>  |                             |   |                                  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |  |   |  |   |  |
| c. LENGTH OF STAY IN 1b <u>Life</u>  |                             |   |                                  |  | d. STREET ADDRESS <u>628 E 14 Ave</u>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto. Medical Center</u>  |                             |   |                                  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <u>Elsie Beatha Rowe</u>   |                             |   | 4. DATE OF DEATH                 |  | Month <u>1</u> Day <u>25</u> Year <u>1967</u>   |  |   |  |   |  |
| 5. SEX <u>F</u>  | 6. COLOR OR RACE <u>CAU</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-17-08</u> | 9. AGE (In years last birthday) <u>58</u> yrs.                         | IF UNDER 1 YEAR   | IF UNDER 24 HRS.   |   |  |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                             | 10b. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. MD.</u>  |   | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                         |   |  |   |  |
| 13. FATHER'S NAME <u>William Edward Wood</u>   |                             |   |                                  |  | 14. MOTHER'S MAIDEN NAME <u>Bussey</u>  |  |   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>  |                             | 16. SOCIAL SECURITY NO. <u>413-28-8614</u>  |                                  | 17. INFORMANT <u>Patient's Chart</u>                                   |   | Address  |   |  |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  |                             |   |                                  |  |   |  |   |  |   |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>   |                             |   |                                  |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary insufficiency</u>   |                             |   |                                  |  |   |  |   |  |   |  |
| (c) <u>Arteriosclerotic cardiovascular disease</u>   |                             |   |                                  |  |   |  |   |  |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Ampulla of Vater</u>   |                             |   |                                  |  |   |  |   |  |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |                             |   |                                  |  |   |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                             |   |                                  |  |   |  |   |  |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |                             |   |                                  |  |   |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year   |                             | 20d. INJURY OCCURRED  |                                  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)                               |   |  |   |  |
| Hour a.m. p.m.   |                             | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>     |                                  |  |   |  |   |  |   |  |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. |                             |   |                                  |  |   |  |   |  |   |  |
| 22a. SIGNATURE <u>Edmund De Murchena</u>   |                             |   |                                  |  | M.D. ATTENDING PHYS. <input type="checkbox"/>   |  | MED. DIRECTOR <input type="checkbox"/>          |  | STAFF PHYS. <input checked="" type="checkbox"/> |  |
| 22c. PHYSICIAN'S NAME (Type) <u>G.B.M.C.</u>   |                             |   |                                  |  | 22d. ADDRESS  |  | 22b. DATE SIGNED <u>1/25/67</u>                 |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |                             | 23b. DATE THEREOF <u>1/30/67</u>  |                                  | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>           |   | 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u> |   |  |   |  |
| 24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>   |                             |   |                                  |  | 25a. REC'D BY REGISTRAR <u>JAN 26 1967</u>  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |  |   |  |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

00413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00416

|   |   |  |  |
|---|---|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lansdowne</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Lansdowne</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>236 Second Avenue</b>  |   | e. STREET ADDRESS<br><b>236 Second Avenue</b>  |  |
| 3. NAME OF DECEASED (Type or print) <b>ELMER C. RUSSELL SR.</b>   |   | 4. DATE OF DEATH <b>January 25, 1967</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <b>6-27-1894</b>                          |
| 9. AGE (In years last birthday) <b>72</b> yrs   |   | 10. IF UNDER 1 YEAR Months Days  | 11. IF UNDER 24 HRS. Hours Mins                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Auditor</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>B &amp; O RR</b>   | 11. BIRTHPLACE (State or foreign country)<br><b>Penna.</b> |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   | 13. FATHER'S NAME<br><b>Charles Russell</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Margaret</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |  |
| 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT Address<br><b>Mrs. Blanche C. Russell, 236 Second Ave.</b>   |  |
| 18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b><br>422.1 DUE TO (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____   |   | INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pt. known to have had cirrhosis in 1963</b>   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>Where <input type="checkbox"/> at work <input type="checkbox"/> Nat'l <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)   | 20f. (City or town) (County) (State)                       |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |  |
| 22. DATE SIGNED <b>1/24/67</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |   | 23b. DATE THEREOF<br><b>1-28-1967</b>  |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge Cemetery</b>   |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Howard County, Maryland</b>  |  |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 27 1967</b>  |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   | 26. REGISTRAR'S SIGNATURE  |  |

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

*James N. Frederick*  
1311 Francis Ave. Balt. 22  
J.N. Frederick

CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

Address (Street, city, town, or county)



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                     |  |   |  |  |  |   |  |  |  |
|---|--|-------------------------------------|--|---|--|--|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                                     |  |   |  |  |  |   |  |  |  |
| 00414 CERTIFICATE OF DEATH 00417  |  |                                     |  |   |  |  |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b> MARYLAND   |  |                                     |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b> b. COUNTY<br><b>Balto.</b> |  |   |  |  |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 12</b>   |  |                                     |  |   |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 12</b>                                    |  |   |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>506 Overbrook Rd.</b>  |  |                                     |  |   |  | d. STREET ADDRESS<br><b>506 Overbrook Rd.</b>  |  |   |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Vasiliky Sakelos</b>   |  |                                     |  |   |  | 4. DATE OF DEATH<br>Month Day Year<br><b>1 22 19 67</b>  |  |   |  |  |  |
| 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b>        |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10-10-1891</b>  |  | 9. AGE (In years last birthday)<br><b>75</b> yrs. |  | IF UNDER 1 YEAR IF UNDER 24 HRS.<br>Months Days Hours Min.       |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                     |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Greece</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>        |  |  |  |
| 13. FATHER'S NAME<br><b>Constantine Hanges</b>  |  |                                     |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Georgia Papacoultsoula</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>  |  |                                     |  | 16. SOCIAL SECURITY NO.<br><b>213-34-4532</b>   |  | 17. INFORMANT<br><b>Mrs. Peter Calvert</b>   |  |   |  | Address<br><b>Above</b>  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction, acute</b><br>420.1<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b><br>DUE TO (c) <b></b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b> |  |                                     |  |   |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 hrs</b><br><b>4+3/4</b> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                                     |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |                                     |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)              |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Feb 25, 1963</b> to <b>Jan 22, 1967</b> , that (I) (we) last saw the deceased alive on <b>Dec 27, 1966</b> , and that death occurred at <b>8:30 AM</b> , from the causes and on the date stated above.   |  |                                     |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><b>Fredrick J. Vollmer</b>  |  |                                     |  |   |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>            |  | 22b. DATE SIGNED<br><b>1-23-67</b>                |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>F. Vollmer</b>   |  |                                     |  |   |  | 22d. ADDRESS<br><b>6100 York Rd., Balto. 12, Md.</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Entombment</b>  |  | 23b. DATE THEREOF<br><b>1-25-67</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn</b>   |  | 23d. LOCATION (City, town or county) (State)<br><b>Woodlawn Md.</b>  |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>  |  |                                     |  |   |  | ADDRESS<br><b>4905 York Rd., Balto.</b>  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1967</b>     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles George</b>              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00415

CERTIFICATE OF DEATH

00418

|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b><br>c. LENGTH OF STAY IN Tb<br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rosewood State Hospital</b>   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution) Residence before admission<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b> ✓<br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b> 12.1<br>d. STREET ADDRESS <b>6905 Windsor Mill Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED (Type or print)<br>First <b>Robert</b> Middle <b>Mitchell</b> Last <b>SAWYER</b>  |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>22</b> Year <b>1967</b>  |  |
| 5 SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8 DATE OF BIRTH <b>5-9-41</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dependent</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>   | 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Maryland</b> |
| 13. FATHER'S NAME <b>Renzy Mitchell Sawyer</b>   |   | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>  |   | 16. SOCIAL SECURITY NO. <b>none</b>   |  |
| 17. INFORMANT <b>Rosewood Records, Owings Mills, Md.</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Electrolyte Imbalance</b><br>DUE TO <b>041X</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>13. (b) Emphysema Right Lungs</b><br>DUE TO <b>Chronic - Strongly Acidosis</b><br>last <b>13. (c) Hypertension</b> |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>2-27, 1962</b> to <b>1-22, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-22, 1967</b> , and that death occurred at <b>5:30 AM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE <b>Esteban V. Diaz</b>  |   | 22b. DATE SIGNED  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>ESTEBAN V. DIAZ</b>  |   | 22d. ADDRESS <b>321-E. BELCREST - BELAIR MD</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  | 23b. DATE THEREOF <b>1/24/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn</b>  | 23d. LOCATION (City or town) (County) (State) <b>Woodlawn, Md.</b>             |
| 24. FUNERAL DIRECTOR <b>Wm. J. Dickson &amp; Sons</b>  |   | 25a. REC'D BY REGISTRAR <b>North &amp; Anna</b>   |  |
| 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>  |   | DATE <b>JAN 25 1967</b>   |  |

21217





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.

VR A15 (4)  
20 M 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00416

00419

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY _____                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |   | c. LENGTH OF STAY IN 1b   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b> <b>21214</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |   | d. STREET ADDRESS<br><b>1806 Heathfield Road</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |
| 3. NAME OF DECEASED<br>(Type or print)<br>First Middle Last<br><b>Mary M. SCHOBER</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>January 11 19 67</b>   |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>9-10-83</b>  |
| 9. AGE (In years last birthday)<br><b>83</b> yrs.  |   | IF UNDER 1 YEAR<br>Months Days  | IF UNDER 24 HRS.<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>                                      |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME<br><b>George Kraus</b>  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Wilhemina Brauch</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>                                     |   |
| 16. SOCIAL SECURITY NO<br><b>2I6 07 2262</b>   |   | 17. INFORMANT<br>Address<br><b>Mrs. C. Loretta Link 1806 Heathfield Balto.</b>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Myocardial Ischemia -Coronary arteriosclerosis</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterial Embolism</b><br>DUE TO<br>(c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Cholecystectomy - Exploration of Common Bile Duct</b>   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                 |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 30th, 1966</b> to <b>Jan. 11 19 67</b> , that (I) (we) last saw the deceased alive on <b>Jan. 11 19 67</b> , and that death occurred at <b>4:05 A.M.</b> from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>Roberto O. Ferrer</b>   |   | 22b. DATE SIGNED<br><b>Jan. 11 19 67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Roberto O. Ferrer M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Road, Towson 21204, Maryland.</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>I/I4/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Holy Redeemer Cem.</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Balto. Md.</b>  |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><b>Leonard J. Ruck Inc. Balto. Md.</b>  |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 11 1967</b>  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00417

00420

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

St. Joseph's Hospital

3. NAME OF DECEASED (Type or print)

First

Middle

Last

Rose

Schonhoff

5. SEX

F

6. COLOR OR RACE

W

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

6-26-80 82

4. DATE OF DEATH

Month

Day

Year

Jan.

30

19 67

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alexander McCoy

14. MOTHER'S MAIDEN NAME

Katherine Goob

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give year or dates of service)

No

220-54-7277

16. SOCIAL SECURITY NO. 17. INFORMANT

Address

Mrs. Mary C. Thomas - 6207 Marglenn Avenue

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)

PULMONARY EMBOLISM

465X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

FRACTURE, LEFT HIP

20a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING CAUSE OF DEATH ☒

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

FELL OUT OF BED AT HOME

20c. TIME OF INJURY Month, Day, Year Hour, a.m., p.m.

JAN 10, 1967

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

HOME

20f. (City or town)

BALTIMORE

(County)

(State)

MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

William A. Pillsbury

M.D.

EXAMINER'S NAME (Type)

William A. Pillsbury

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

1/31/67

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

2-1-67

22c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

22d. LOCATION (City, town, or country)

Baltimore, Maryland

23. FUNERAL DIRECTOR

ADDRESS

John C. Miller Inc. - 6415 Belair Rd. - 21206

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

DATE FEB 7 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



00418

## CERTIFICATE OF DEATH

00421

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br>MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>RANDALLSTOWN</u>  |  | c. LENGTH OF STAY IN 1b<br><u>Baltimore</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>BALTIMORE COUNTY HOSPITAL</u>   |  | d. STREET ADDRESS<br><u>2807 HOLLINS FERRY</u>   |   |
| 3 NAME OF DECEASED<br>(Type or print) <u>JOHN G. SCHULER</u>   |  | 4 DATE OF DEATH<br>Month <u>1</u> Day <u>19</u> Year <u>67</u>   |   |
| 5 SEX<br><u>MALE</u>   | 6. COLOR OR RACE<br><u>WHITE</u>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>4/24/93</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>  |  | 11. BIRTHPLACE (County & State or foreign country)<br><u>BALTO. MD.</u>  |   |
| 10b. KIND OF BUSINESS OR INDUSTRY  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>Fred Schuler</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Barbara Achler</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>26-Aug-18-</u>   |  | 16. SOCIAL SECURITY NO   |   |
| 17. INFORMANT<br><u>Mrs. Ada Schuler - same</u>  |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u><br>DUE TO (b) <u>Arteriosclerotic Heart Disease</u><br>DUE TO (c) <u>Branch-... ..</u>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 MONTHS</u>  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Acute Renal Failure</u>  |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. <u>19</u><br>p.m.  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work or work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-15-67</u> , 19 <u>67</u> , to <u>1/19/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-19-67</u> , 19 <u>67</u> , and that death occurred at <u>11:20 PM</u> , from causes and on the date stated above. |  |  |   |
| 22a. SIGNATURE<br><u>Dr. Evangelina Ramos</u>  |  | 22b. DATE SIGNED   |   |
| 22c. PHYSICIAN'S NAME (Type) <u>EVANGELINA RAMOS</u>   |  | 22d. ADDRESS   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>24 Jan 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Baltimore National Cem.</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR<br><u>George J. Gonce-4001 Ritchie Hwy., Baltimore</u>  |  | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 25 1967</u>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00419

CERTIFICATE OF DEATH

00422

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u>   |   | c LENGTH OF STAY IN 1b<br><u>Baltimore</u>   |   |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>6103 TALLES ROAD</u>  |   | d STREET ADDRESS<br><u>6103 TALLES ROAD</u>  |   |
| 3. NAME OF DECEASED<br>(Type or print) <u>MARIAN SCHWARTZMAN</u><br>First Middle Last   |   | 4. DATE OF DEATH <u>JANUARY 22, 19 67</u><br>Month Day Year  |   |
| 5. SEX <u>FEMALE</u>  | 6 COLOR OR RACE <u>WHITE</u>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>68</u> yrs.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSEWIFE</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>AT HOME</u>  |   |
| 11. BIRTHPLACE (County & State or foreign country)<br><u>BALTIMORE MARYLAND MD.</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>BORIS ALPER</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>ETTA ?</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>NO</u>  |   | 16. SOCIAL SECURITY NO<br><u>UNKNOWN</u>   |   |
| 17. INFORMANT<br><u>MR. BORIS SCHWARTZMAN, 5125 NELSON AVENUE</u>   |   | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>coronary arteriosclerosis</u><br>DUE TO<br>(c) <u>?</u> |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>?</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>Depressive Reaction</u>   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street off ce bldg., etc)   | 20f. (City or town) (County) (State)  |
| 21 I certify that (1) (this hospital) attended the deceased from <u>1963</u> , to <u>1-22, 1967</u> , that (1) (we) last saw the deceased alive on <u>April 19 66</u> , and that death occurred at <u>1P</u> M, from causes and on the date stated above  |   |  |   |
| 22a. SIGNATURE<br><u>Stanley R Steinbach</u>  |   | 22b. DATE SIGNED<br><u>1-22-67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>DR. STANLEY R. STEINBACH</u>   |   | 22d. ADDRESS<br><u>11 SLADE AVENUE</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 23b. DATE THEREOF<br><u>1/23/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>ANSHE EMUNAH</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>BALTIMORE, MARYLAND</u> |
| 24. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS. INC., 6010 REISTERSTOWN</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 26 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00420

## CERTIFICATE OF DEATH

00423

|  |                                 |  |  |  |  |   |  |
|--|---------------------------------|--|--|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                 |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                 |  | c. LENGTH OF STAY IN 1b<br><b>10mth27dys</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 34, Md.</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                 |  |  | d. STREET ADDRESS<br><b>3024 Fifth Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Natalie</b> Middle <b>Serovy</b> Last <b>Serovy</b>  |                                 |  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>10</b> Year <b>19 67</b>   |  |   |  |
| 5 SEX<br><b>female</b>   | 6 COLOR OR RACE<br><b>white</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>October 2, 1910</b>    |  | 9 AGE (In years last birthday)<br><b>56</b> yrs  | IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> |  |
| 10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Penna.</b>  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>Frank Azymanski</b>  |                                 |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Vearlie Londell</b>   |  |   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |                                 | 16 SOCIAL SECURITY NO<br><b>176-09-8175</b>  |  | 17. INFORMANT<br>Address <b>Records: SPRING GROVE STATE HOSPITAL</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)          |                                 |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>Pick's Disease</b>   |                                 |  |  |  |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f (City or town) (County) (State)   |  |
| 21. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>Feb. 7, 1966</b> to <b>Jan. 10, 1967</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>Jan. 10, 1967</b> , and that death occurred at <b>12:45 a.m.</b> from causes and on the date stated above. |                                 |  |  |  |  |   |  |
| 22a SIGNATURE<br><b>Anthony J. Young, M.D.</b>   |                                 |  |  | 22b. DATE SIGNED<br><b>1-10-67</b>   |  | 22c. PHYSICIAN'S NAME (Type)  |  |
| 22d ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |                                 |  |  | 22e REC'D BY REGISTRAR<br><b>DATE JAN 13 1967</b>  |  |   |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                                 | 23b DATE THEREOF<br><b>1/11/66</b>   |  | 23c NAME OF CEMETERY OR CREMATORY<br><b>ST. MARK MEM. PK.</b>  |  | 23d LOCATION (City or Town) (County) (State)<br><b>LOWER BURRELL, PA.</b>   |  |
| 24. FUNERAL DIRECTOR<br><b>E.S. MALNAB</b>   |                                 |  |  | 25b REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |  |   |  |



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VR A15 (4)  
25M 1/67

BP

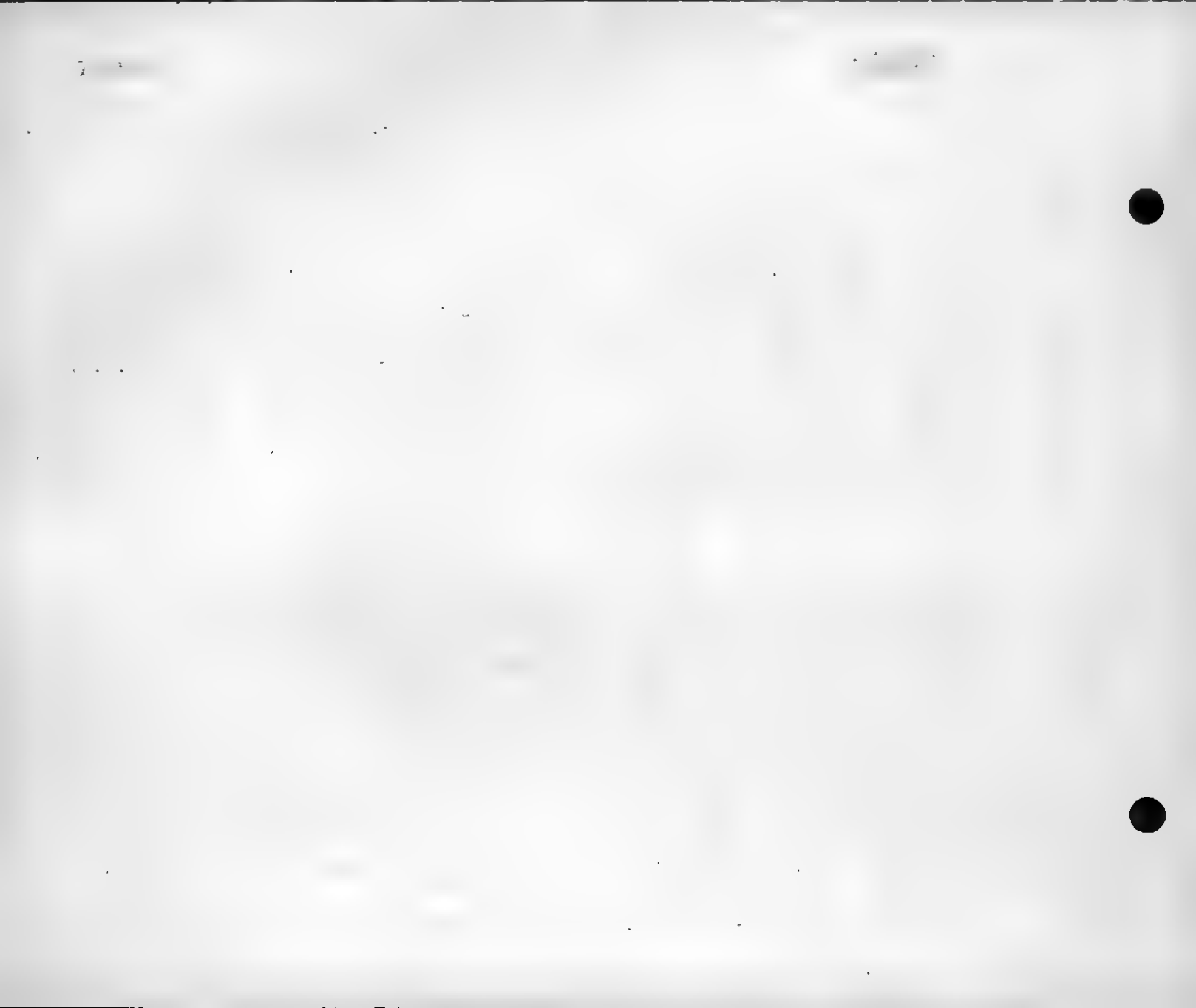
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00421

CERTIFICATE OF DEATH

00424

|  |   |   |  |
|--|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. LENGTH OF STAY IN 1b<br><b>Baltimore</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Summit Nursing Home</b>   |   | d STREET ADDRESS<br><b>405 Swann Avenue</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>IRENE M. SESSIONS</b>  |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>29</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6-24- 1888</b>  |
| 9. AGE (In years last birthday)<br><b>78</b> yrs   |   | 10. IF UNDER 1 YEAR Months Days Hours Min.<br><b>19 67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Henry Hellmann</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Blaney</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><b>Miss Mary Louise Sessions, 405 Swann Ave.</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>153.8</b> IMMEDIATE CAUSE (a) <b>Carcinoma Colon</b><br>DUE TO (b) <b>Pulmonary Emphysema</b><br>DUE TO (c) <b>Pulmonary Hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21 I certify that (I) (this hospital) attended the deceased from <b>1954</b> , 19 <b>Jan 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Jan 28 1967</b> , and that death occurred at <b>2:15 PM</b> , from causes and on the date stated above.  |   |   |  |
| 22a. SIGNATURE<br><b>Dr. John C. Healy</b>   |   | 22b. DATE SIGNED<br><b>1/30/67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. John C. Healy</b>   |   | 22d. ADDRESS<br><b>1311 Francis Avenue, Balto., Md.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>2- 1-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Druid Ridge Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore County, Maryland</b> |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 31 1967</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |   |   |  |



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VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |  |  |  |  |  |   |   |  |  |
|--|--|--|--|--|--|--|--|---|---|--|--|
| 00422  |  |  |  |  |  | 00425  |  |   |   |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u><br>c. LENGTH OF STAY IN 1b <u>7 days</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>  |  |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u><br>b. COUNTY <u>Virginia</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ANNANDALE</u><br>d. STREET ADDRESS <u>6922 Terrace Pl.</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |   |  |  |
| 3. NAME OF DECEASED (Type or print) First Middle Last<br><u>WARNER Cornelious Settle</u>   |  |  | 4. DATE OF DEATH Month Day Year<br><u>JAN 5 1967</u> |  |  | 5. SEX <u>Male</u>   |  |   | 6. COLOR OR RACE <u>CAU</u>                                 |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  | 8. DATE OF BIRTH <u>12/4/21</u>                      |  |  | 9. AGE (In years last birthday) <u>45</u> yrs.   |  |   | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NGR</u>   |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>ANNANDALE Gulf</u>  |  |  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>WARSAW, Virginia</u> |   |  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |  |  | 13. FATHER'S NAME <u>Warner, Settle</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Brook</u>                                       |   |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  |  | 16. SOCIAL SECURITY NO. <u>212-30-1230</u>   |  |  |  | 17. INFORMANT <u>Patient's Chart</u> Address                                |   |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE RENAL FAILURE</u><br>613X DUE TO <u>ACUTE CORTICAL NECROSIS OF KIDNEYS</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PERITONITIS FROM PERFORATED PEPTIC ULCER</u> |  |  |  |  |  |  |  |   |   | INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>      |  |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |  |  |  |  |   |   |  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)           |  |  |  |   |   |  |  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |  |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)      |   |  |  |
| 20f. (City or town) (County) (State)   |  |  |  |  |  |  |  |   |   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 29th, 1966</u> , to <u>Jan. 5th, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 5th, 1967</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.   |  |  |  |  |  |  |  |   |   |  |  |
| 22a. SIGNATURE <u>M. I. MacGregor</u>  |  |  |  |  |  |  |  |   |   | 22b. DATE SIGNED <u>Jan. 5th, 1967</u>               |  |
| 22c. PHYSICIAN'S NAME (Type) <u>M. I. MAC GREGOR</u>   |  |  |  |  |  |  |  |   |   | 22d. ADDRESS <u>Greater Baltimore Medical Center</u> |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>  |  |  |  | 23b. DATE THEREOF <u>1/9/67</u>  |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Arl. Cemetery</u>                     |   |  |  |
| 23d. LOCATION (City, town or county) (State) <u>Arlington VA.</u>  |  |  |  | 24. FUNERAL DIRECTOR <u>RJ Murphy</u> ADDRESS <u>Arlington, VA.</u>                                    |  |  |  | 25a. REC'D BY REGISTRAR <u>JAN 11 1967</u>                                  |   |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>  |  |  |  |  |  |  |  |   |   |  |  |



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VR A15 (4)  
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |   |  |   |  |  |  |   |  |   |  |
|---|--|---|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |   |  |   |  |  |  |   |  |   |  |
| 00423   |  | CERTIFICATE OF DEATH  |  |   |  | 00426  |  |   |  |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b><br>c. LENGTH OF STAY IN 1b. <b>29 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Greater Balto. Medical Center</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>MD.</b><br>b. COUNTY <b>BALTO.</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RANDALLSTOWN</b><br>d. STREET ADDRESS <b>3411 CARROLL AVENUE</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 3. NAME OF DECEASED (Type or print)<br>First <b>EDMUND</b> Middle <b></b> Last <b>SHAW JR.</b><br>4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>25</b> Year <b>1967</b>   |  | 5. SEX <b>M</b><br>6. COLOR OR RACE <b>W</b><br>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br>8. DATE OF BIRTH <b>1/17/1896</b><br>9. AGE (In years last birthday) <b>70</b> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETD. FURNITURE SALESMAN</b><br>10b. KIND OF BUSINESS OR INDUSTRY <b>FURNITURE</b><br>11. BIRTHPLACE (County & State, or foreign country) <b>BALA. PA.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>USA.</b> |  | 13. FATHER'S NAME <b>EDMUND SHAW SR.</b><br>14. MOTHER'S MAIDEN NAME <b>LYDIA MYERS</b> |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b><br>16. SOCIAL SECURITY NO. <b>213-10-5760</b><br>17. INFORMANT <b>Katherine Q. Shaw</b><br>Address <b>3411 Carroll Ave. Randallstown</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>BRONCHO PNEUMONIA</b><br>(b) <b>CEREBRAL INFARCTION</b><br>(c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)             |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>ONE WEEK</b>   |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |   |  |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br>20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.<br>20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br>20f. (City or town) (County) (State) |  | 21. I certify that (I) (this hospital) attended the deceased from <b>12-28-1966</b> , to <b>1-25-1967</b> , that (I) (we) last saw the deceased alive on <b>1-25-1967</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.  |  | 22a. SIGNATURE <b>E. K. S. Narayanan</b><br>22b. DATE SIGNED <b>1-25-1967</b><br>M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22c. PHYSICIAN'S NAME (Type) <b>EDATHIL K. S. NARAYANAN</b><br>22d. ADDRESS <b>GREATER BALTIMORE MEDICAL CENTER TOWSON, MARYLAND 21204</b>   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23b. DATE THEREOF <b>Jan 28/67</b><br>23c. NAME OF CEMETERY OR CREMATORY <b>Union Ridge Cemetery, Pikesville, Md.</b><br>23d. LOCATION (City, town or county) (State) <b>Pikesville, Md.</b>  |  | 24. FUNERAL DIRECTOR <b>Loring Byers</b><br>ADDRESS <b>8728 Liberty Road</b><br>25a. REC'D BY REGISTRAR <b>JAN 31 1967</b><br>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |  |   |  |  |  |   |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00424

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00427

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore TOWSON</u><br>c. LENGTH OF STAY IN ID <u>MD.</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Baltimore Medical Center</u>   |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution? Residence before admission)<br>e. STATE <u>Md.</u> f. COUNTY <u>BALTIMORE</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore COCKEYSVILLE</u><br>d. STREET ADDRESS <u>3 Hillside AVE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Arthur</u> Middle <u>William</u> Last <u>Shock</u>  |  |  | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>23</u> Year <u>1967</u>  |  |  |
| 5. SEX <u>M</u>   |  |  | 6. COLOR OR RACE <u>CAU.</u>   |  |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  | 8. DATE OF BIRTH <u>6-7-1896</u>   |  |  |
| 9. AGE (In years last birthday) <u>70</u> yrs.  |  |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAILER - RETIRED</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>H.T. CAMPBELL CORP.</u>   |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>   |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| 13. FATHER'S NAME <u>George H. Shock</u>  |  |  | 14. MOTHER'S MAIDEN NAME <u>DARKS REBECCA PARKS</u>  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>   |  |  | 16. SOCIAL SECURITY NO. <u>216-07-2001</u>   |  |  |
| 17. INFORMANT <u>FAMILY RECORDS</u>   |  |  | Address  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardio respiratory failure</u><br>DUE TO (b) <u>Uremia</u><br>DUE TO (c) <u>Carcinoma of bladder</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <u>19</u>  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  | 20f. (City or town) (County) (State)   |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27, 1966</u> , to <u>Jan. 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan. 23, 1967</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.   |  |  |  |  |  |
| 22a. SIGNATURE <u>Robert W. Smith</u>   |  |  | 22b. DATE SIGNED <u>Jan. 23, 1967</u>  |  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |  | 22d. ADDRESS   |  |  |
| 23a. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>  |  |  | 23b. DATE THEREOF <u>JAN. 26, 1967</u>   |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>SATER'S CEMETERY</u>  |  |  | 23d. LOCATION (City, town or county) (State) <u>LUTHERVILLE, MARYLAND</u>  |  |  |
| 24. FUNERAL DIRECTOR <u>John Burne' Sons, Towson, Md.</u>   |  |  | 25a. REC'D BY REGISTRAR <u>JAN 31 1967</u>   |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>James Judge</u>   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
21 M 1/66

00425

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00428

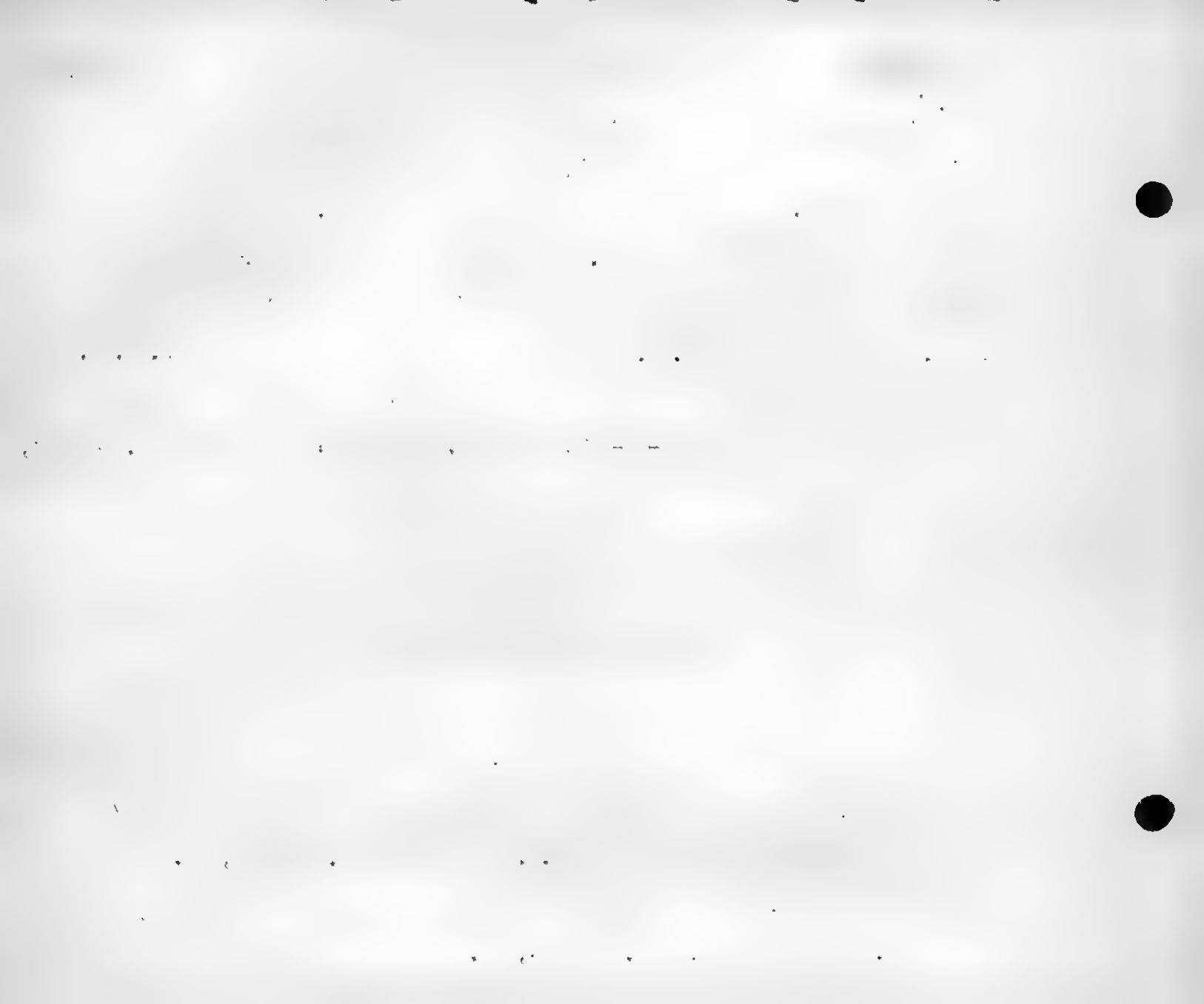
|   |   |   |  |
|---|---|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                 |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. LENGTH OF STAY IN 1b<br><b>3 days</b>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Lansdowne</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |   | d. STREET ADDRESS<br><b>339 Fifth Avenue</b>  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |
| 3 NAME OF DECEASED<br>(Type or print)<br>First <b>Berlie</b> Middle <b>M.</b> Last <b>Shrieves</b>  |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>13</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Nov. 3, 1903</b>  |
| 9. AGE (In years)<br><b>63</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>laborer</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State or foreign country)<br><b>Virginia</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Alfred Shrieves</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Emma Turner</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO<br><b>215-09-4735</b>  |  |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>  |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY<br><b>493X</b> IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>(c) _____<br>DUE TO |   |   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Generalized and cerebral arteriosclerosis - Chronic alcoholism</b>   |   |   |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Jan. 10, 1967</b> to <b>Jan. 13, 1967</b> , that <del>it</del> (we) last saw the deceased alive on <b>Jan. 13, 1967</b> , and that death occurred at <b>1920</b> M, from causes on the date stated above.                   |   |   |  |
| 22a. SIGNATURE<br><i>Stella Wachsler</i>  |   | 22b. DATE SIGNED<br><b>1-13-67</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachsler, M.D.</b>  |   | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>1-16-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                          |
| 24. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 17 1967</b>  |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |                                  |   |   |  |   |   |  |  |  |
|--|----------------------------------|---|---|--|---|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |                                  |   |   |  |   |   |  |  |  |
| 00426  |                                  |   |   |  | 00429   |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b><br>c. LENGTH OF STAY IN 1b<br><b>7 Years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>75 Del Rio Rd.</b>                 |                                  |   |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b><br>d. STREET ADDRESS<br><b>75 Del Rio Rd.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <b>Harry</b> Middle <b>M.</b> Last <b>Siegle</b>   |                                  |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>9</b> Year <b>19 67</b> |  |   |   |  |  |  |
| 5. SEX<br><b>Male</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/7/96</b>                                       | 9. AGE (In years last birthday)<br><b>70</b> yrs.  | IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>31</b>   | IF UNDER 24 HRS.<br>Hours <b>1</b> Min. <b>31</b>   |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Const. Foreman, Retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>M. A. Long</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>Christian Siegle</b>   |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Henrietta Schaffer</b>  |   |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |                                  | 16. SOCIAL SECURITY NO.<br><b>216-05-5352</b>   |   | 17. INFORMANT (Son)<br><b>Harry M. Siegle Jr.</b>  |   | Address <b>Maryland</b><br><b>75 Del Rio Rd. Dundalk,</b>   |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cancer of He stomach</b><br>DUE TO (b) <b>metastases</b><br>DUE TO (c) <b>metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  |   |   |  |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |   |  |   |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>oct 10, 1966</b> to <b>1-9, 1967</b> , that (I) (we) last saw the deceased alive on <b>1-9, 1967</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above.  |                                  |   |   |  |   |   |  |  |  |
| 22a. SIGNATURE<br><b>Marcos Levin</b>  |                                  |   |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> |   | 22b. DATE SIGNED<br><b>1/10/67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Marcos Levin,</b>   |                                  | M.D.  |   | 22d. ADDRESS<br><b>201 Wise Ave. Dundalk, Md. 21222</b>  |   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                                  | 23b. DATE THEREOF<br><b>1/12/67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore Cemetery</b>  |   | 23d. LOCATION (City, town or county) (State)<br><b>Baltimore, Maryland</b>                        |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>John J. Duda</b>  |                                  |   |   | ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 12 1967</b>   |  |  |  |
|  |                                  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>  |   |   |  |  |  |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00427

## CERTIFICATE OF DEATH

00430

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE<br><b>Maryland</b>  |   | b. COUNTY<br><b>Prince George</b>  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |   | c. LENGTH OF STAY IN 1b<br><b>15 yrs.</b>   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Hyattsville, Maryland</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospite, give street address)<br><b>Rosewood State Hospital</b>  |   | d. STREET ADDRESS<br><b>2002 Ruxton Street</b>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Janet Alice SIMONS</b>  |   | 4. DATE OF DEATH<br>Month Day Year<br><b>1 28 1967</b>  |   |  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2/5/49</b>   | 9. AGE (In years last birthday)<br><b>17</b> yrs.  | IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>17</b>                            |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>dependent</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Washington, D.C.</b>                                   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   | 13. FATHER'S NAME<br><b>Howard Julian Simons</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Patricia Jane Pratt</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT<br>Address<br><b>Rosewood Records, Owings Mills, Maryland</b>                                      |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Orthostatic Necrotizing Pneumonia</b><br>DUE TO <b>Aspiration of Gastric Contents</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Marked mental Retardation</b><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>17 yrs</b> |   |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 wks</b><br><b>4 yrs</b><br><b>17 yrs</b> |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |   |   |   |  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town)   | (County)   | (State)   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>10-21-67</b> to <b>1-28-68</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1-28-68</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above.  |   |   |   |  |   |
| 22a. SIGNATURE<br><b>Harry G. Butler</b>   |   | M.D.  | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | 22b. DATE SIGNED<br><b>1-30-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Harry G. Butler, M.D.</b>   |   | 22d. ADDRESS<br><b>Rosewood Lane, Owings Mills, Maryland</b>  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>2/1/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Rosewood Cemetery</b>  | 23d. LOCATION (City, town or county) (State)<br><b>Owings Mills, Md.</b>  |  |   |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><b>J. F. Eline &amp; Sons</b>  |   | ADDRESS<br><b>Reisterstown, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE<br><b>FEB 3 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                                |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

00428

CERTIFICATE OF DEATH

00431

|  |                                  |   |  |   |  |   |  |
|--|----------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓ |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>  |                                  |   | c. LENGTH OF STAY IN 1b<br><b>1 1/4 years</b>                        |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Kensington,</b> |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><b>Rosewood State Hospital</b>  |                                  |   |  | d. STREET ADDRESS<br><b>10413 Ewell Avenue</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Deborah</b> Middle <b>Lynn</b> Last <b>SLETTTO</b>   |                                  |   |  | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>13</b> Year <b>19 67</b>  |  |   |  |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><b>3-6-63</b>                                    |   | 9. AGE (In years lost birthday) yrs. <b>3</b>  | IF UNDER 1 YEAR<br>Months <b>3</b> Days <b>13</b> Hours <b>19</b> Min <b>67</b>                   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Dependent</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>  |  | 11. BIRTHPLACE (County & State or foreign country)<br><b>Montgomery Co., Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Ellsworth Omar Sletto</b>  |                                  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Joanne Marie Tolerico</b>  |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no --</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>none</b>  |  | 17. INFORMANT<br>Address <b>Rosewood Records, Owings Mills, Maryland</b>  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CONVULSIVE DISORDER</b> \$<br>DUE TO <b>PROGRESSIVE MUSCULAR ATROPHY</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(WERNICKE-HOFFMAN SYNDROME)</b><br>(c) <b>(WERNICKE-HOFFMAN SYNDROME)</b> |                                  |   |  |   |  | INTERVA. BETWEEN ONSET AND DEATH<br><b>YEARS</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                                  |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |   |  |
| 20c. TIME OF INJURY Month, Day Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc) |   | 20f. (City or town) (County) (State)   |   |  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>2-25</b> , 19 <b>65</b> , to <b>1-13</b> , 19 <b>67</b> , that (X) (we) last saw the deceased alive on <b>1-13</b> , 19 <b>67</b> , and that death occurred at <b>9:20 A.M.</b> from causes and on the date stated above.   |                                  |   |  |   |  |   |  |
| 22a. SIGNATURE<br><b>Harry G. Butler</b>   |                                  |   |  | 22b. DATE SIGNED<br><b>1-13-67</b>  |  | 22c. PHYSICIAN'S NAME (Type)<br><b>Harry G. Butler, M.D.</b>                                      |  |
| 22d. ADDRESS<br><b>Rosewood St. Hosp., Owings Mills, Md.</b>   |                                  |   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)<br><b>Burial</b>  |                                  | 23b. DATE THEREOF<br><b>1-16-1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GATE OF HEAVEN Cem</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Wheaton Mont Md</b>                           |  |
| 24. FUNERAL DIRECTOR<br><b>Robert A. Dyer</b>  |                                  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 23 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |   |  |

23a

23b

23c

23d

24

25a

25b



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00429

CERTIFICATE OF DEATH

00432

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Perry Hall</b>   |   | c. LENGTH OF STAY IN lb<br><b>03.1</b>  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>4018 Klausmier Road</b>  |   | d. STREET ADDRESS<br><b>4018 Klausmier Road</b>   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>JOHN W. SMITH</b>  |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>1</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>male</b>   | 6. COLOR OR RACE<br><b>white</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>Dec. 22, 1902</b>                               |
| 9. AGE (In years last birthday)<br><b>64 yrs.</b>   |   | 10. IF UNDER 1 YEAR<br>Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work no life, even if retired)<br><b>Insurance agent</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Baltimore, Md.</b>  |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Baltimore, Md.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |  |
| 13. FATHER'S NAME<br><b>Albert J. Smith, Sr.</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Katherine Busky</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>   |   | 16. SOCIAL SECURITY NO.<br><b>212-07-2939</b>   |  |
| 17. INFORMANT<br><b>Mrs Marie F Smith 4018 Klausmier Rd</b>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY:<br><b>177X</b><br>IMMEDIATE CAUSE (a) <b>Carcinoma of the prostate</b><br>DUE TO (b) <b>with generalized metastasis</b><br>DUE TO (c) <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>about 2 yrs</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Sept</b> , 19 <b>44</b> , to <b>Jan</b> , 19 <b>67</b> , that (I) (we) lost the deceased alive on <b>1 Jan</b> , 19 <b>67</b> , and that death occurred at <b>9:30 AM</b> , from causes and on the date stated above   |   |   |  |
| 22a. SIGNATURE<br><b>Douglas Lockard</b>  |   | 22b. DATE SIGNED<br><b>2 Jan, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Douglas Lockard</b>  |   | 22d. ADDRESS<br><b>Cockey's Mill Rd, Roseto, Md.</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>burial</b>  | 23b. DATE THEREOF<br><b>1/5/67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b> |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. - Baltimore, Md.</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 1967</b>   |  |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00430

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00433

|   |                                    |  |  |
|---|------------------------------------|--|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>Baltimore</b> MARYLAND  |                                    | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a STATE <b>Maryland</b> b COUNTY <b>Anne Arundel</b>  |  |
| b CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)  |                                    | c LENGTH OF STAY IN 1b   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Benson Ave. &amp; Beltway Overpass</b>   |                                    | e STREET ADDRESS<br><b>Lanyane Apts. Diving &amp; Community Rd.</b>  |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>PAUL WILLIAM SMITH</b>  |                                    | 4 DATE OF DEATH<br>Month Day Year<br><b>1 7 19 67</b>  |  |
| 5 SEX<br><b>Male</b>  | 6 COLOR OR RACE<br><b>White</b>    | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>6/27/44</b>   |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sheet Metal Worker</b>   |                                    | 10b KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><b>22 yrs.</b>  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md</b>  |                                    | 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13 FATHER'S NAME<br><b>Jeremiah Smith</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Vera Keimig</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |                                    | 16 SOCIAL SECURITY NO  |  |
| 17. INFORMANT<br><b>Family</b>  |                                    | Address<br><b>Same</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushing Head Injuries</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |                                    |  | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)   |                                    |  | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)<br><b>Driver in auto-fixed object accident</b>  |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour am <b>12:11 1 7 19 67</b>   |                                    | 20d INJURY OCCURRED<br>While <input type="checkbox"/> not while <input checked="" type="checkbox"/> at work of work  |  |
| 20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)<br><b>Street</b>  |                                    | 20f (City or town) (County) (State)<br><b>Baltimore Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |  |  |
| ACTUAL SIGNATURE<br><b>Rudiger Breiteneker, M.D.</b>  |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASS STANT MED CAL EXAMINER <input checked="" type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input type="checkbox"/><br>Address (Street, city, town, or county) |  |
| 22. DATE SIGNED<br><b>1/7/67</b>  |                                    |  |  |
| 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b DATE THEREOF<br><b>1/11/67</b> | 23c NAME OF CEMETERY OR CREMATORY<br><b>Meadowridge</b>  | 23d LOCATION (City or Town) (County) (State)<br><b>Elkridge Md</b>                               |
| 24 FUNERAL DIRECTOR<br><b>McCully F # 237 Patapsco Ave 21225</b>  |                                    | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 9 1967</b>  |  |
|   |                                    | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

00431

MARYLAND STATE DEPARTMENT OF HEALTH

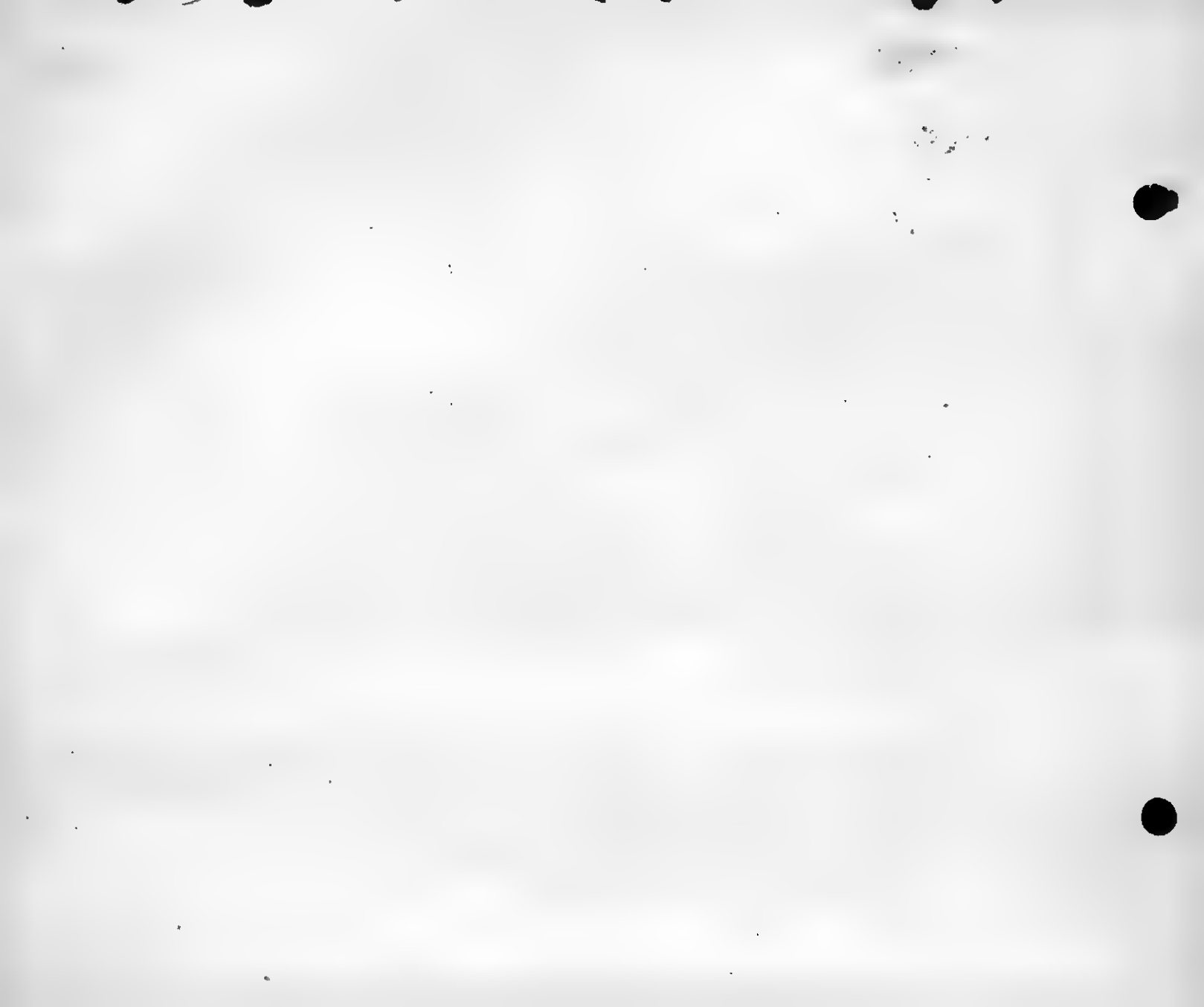
RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00434

|   |  |   |  |   |  |                               |  |  |  |                                 |  |  |  |   |  |  |  |  |  |                                      |  |  |  |
|---|--|---|--|---|--|-------------------------------|--|--|--|---------------------------------|--|--|--|---|--|--|--|--|--|--------------------------------------|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>c. LENGTH OF STAY IN 1b <u>UNK</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Baltimore Medical Center</u>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>421 IL Chester Ave #218</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                               |  |  |  |                                 |  |  |  |   |  |  |  |  |  |                                      |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Rachel Jane Smith</u>  |  | 4. DATE OF DEATH <u>January 29 1967</u> |  | 5. SEX <u>Female</u>  |  | 6. COLOR OR RACE <u>White</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>7/22/19</u> |  | 9. AGE (In years last birthday) <u>47</u> yrs.   |  | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. |  |  |  |  |  |                                      |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>  |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |                               |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>  |  |                                 |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |  |   |  |  |  |  |  |                                      |  |  |  |
| 13. FATHER'S NAME <u>Mose Dooley</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME <u>Martha Ellen Cote Sears</u>   |  |                               |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)  |  |                                 |  | 16. SOCIAL SECURITY NO. <u>216-12-6509</u>   |  |   |  | 17. INFORMANT <u>Medical Records GBMC</u>                              |  |  |  |                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Adenocarcinoma of the breast Rt.</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Metastasis to ovaries &amp; G.</u><br>DUE TO (c) <u>Generalized Carcinomatosis</u> |  |   |  |   |  |                               |  |  |  |                                 |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>17 years</u><br><u>10 years</u><br><u>9 months</u>              |  |   |  |  |  |  |  |                                      |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |   |  |   |  |                               |  |  |  |                                 |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  |   |  |  |  |  |  |                                      |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |                               |  | 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>  |  |                                 |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  |   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |  |  |  | 20f. (City or town) (County) (State) |  |  |  |
| 21. I certify that (I (this hospital) attended the deceased from <u>Dec. 7, 1966</u> , to <u>Jan. 29, 1967</u> , that (II) (we) last saw the deceased alive on <u>Jan. 28 1967</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.   |  |   |  |   |  |                               |  |  |  |                                 |  |  |  |   |  |  |  |  |  |                                      |  |  |  |
| 22a. SIGNATURE <u>Ludilina M. Oteyza</u>  |  |   |  |   |  |                               |  |  |  |                                 |  | 22b. DATE SIGNED <u>Jan. 29, 1967</u>  |  |   |  |  |  |  |  |                                      |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>LUDILINA M. OTEYZA</u>  |  |   |  |   |  |                               |  |  |  |                                 |  | 22d. ADDRESS <u>GBMC - 6701 N. Charles, Balt. MD</u>   |  |   |  |  |  |  |  |                                      |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |  |   |  | 23b. DATE THEREOF <u>2/1/67</u>   |  |                               |  | 23c. NAME OF CEMETERY OR CREMATORY <u>BALTIMORE NATIONAL</u>   |  |                                 |  | 23d. LOCATION (City, town or county) (State) <u>BALTIMORE, MD.</u>                                     |  |   |  |  |  |  |  |                                      |  |  |  |
| 24. FUNERAL DIRECTOR <u>McCULLY FUNERAL HOME 237 PATAPSCO AVENUE</u>  |  |   |  |   |  |                               |  |  |  |                                 |  | 25a. REC'D BY REGISTRAR <u>Jan 31 1967</u>   |  |   |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>                        |  |  |  |                                      |  |  |  |

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00432

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00435

|  |  |   |  |   |  |                              |  |   |  |                                     |  |   |  |  |  |                  |  |
|--|--|---|--|---|--|------------------------------|--|---|--|-------------------------------------|--|---|--|--|--|------------------|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore County</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Mount Wilson, Md.</b><br>c. LENGTH OF STAY IN 1b<br><b>MARYLAND</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>Mount Wilson State Hospital</b>  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE<br><b>Maryland</b><br>COUNTY<br><b>Prince George</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>College Park</b><br>d. STREET ADDRESS<br><b>4703 Erie St.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |                              |  |   |  |                                     |  |   |  |  |  |                  |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Martha</b> First<br><b>Curlis</b> Middle<br><b>Southall</b> Last  |  | 4. DATE OF DEATH<br>Month<br><b>1.</b><br>Day<br><b>14</b><br>Year<br><b>1967</b> |  | 5. SEX<br><b>F</b>  |  | 6. COLOR OR RACE<br><b>W</b> |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>10.18.89</b> |  | 9. AGE (In years last birthday)<br><b>77</b> yrs.                 |  | IF UNDER 1 YEAR<br>Months<br>Days<br>Hours<br>Min. |  | IF UNDER 24 HRS. |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  |   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  |                              |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  |                                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                      |  |  |  |                  |  |
| 13. FATHER'S NAME<br><b>Charles Macou Southall</b>   |  |   |  |   |  |                              |  | 14. MOTHER'S MAIDEN NAME<br><b>Alice Mooers</b>   |  |                                     |  |   |  |  |  |                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>---</b>   |  |                              |  | 17. INFORMANT<br><b>Records, Mt. Wilson State Hospital</b>  |  |                                     |  | Address   |  |  |  |                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>420.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |   |  |   |  |                              |  |   |  |                                     |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 weeks</b>                |  |  |  |                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |                              |  |   |  |                                     |  |   |  |  |  |                  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m.<br>p.m.<br><b>19</b>   |  |   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |                              |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                                     |  | 20f. (City or town) (County) (State)                              |  |  |  |                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>12.29, 1966</b> , to <b>1.14, 1967</b> , that (I) (we) last saw the deceased alive on <b>1.14.1967</b> , and that death occurred at <b>6:25 AM</b> , from the causes and on the date stated above.  |  |   |  |   |  |                              |  |   |  |                                     |  |   |  |  |  |                  |  |
| 22a. SIGNATURE<br><b>Wm. Newcomer</b>  |  |   |  |   |  |                              |  |   |  |                                     |  | 22b. DATE SIGNED<br><b>1.14.67</b>                                |  |  |  |                  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Wm. Newcomer, M.D., Superintendent</b>  |  |   |  |   |  |                              |  | 22d. ADDRESS<br><b>Mount Wilson, Maryland</b>   |  |                                     |  |   |  |  |  |                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 23b. DATE THEREOF<br><b>Jan 17, 1967</b>  |  |                              |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Washington Memorial Park</b>   |  |                                     |  | 23d. LOCATION (City, town or county) (State)<br><b>Simpson Ra</b> |  |  |  |                  |  |
| 24. FUNERAL DIRECTOR<br><b>F Gascho sons Hyattsville, Md</b>   |  |   |  |   |  |                              |  | 25a. REC'D BY REGISTRAR<br><b>JAN 16 1967</b>   |  |                                     |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>                |  |  |  |                  |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)  
2DM 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

|   |                               |  |                                  |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |                               | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>             |                                  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |                               | c. LENGTH OF STAY IN 1b <u>17 days</u>   |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER Baltimore Medical Center</u>  |                               | d. STREET ADDRESS <u>554 East 38th St.</u>   |                                  |
| 3. NAME OF DECEASED (Type or print) <u>CLARA MAY SPIELMAN</u>   |                               | 4. DATE OF DEATH <u>Jan. 15 1967</u>   |                                  |
| 5. SEX <u>Female</u>  | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-12-81</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs.  |                               | 10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>  |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Registered Nurse</u>   |                               | 10b. KIND OF BUSINESS OR INDUSTRY <u>Medical</u>   |                                  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co., Md.</u>  |                               | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                                  |
| 13. FATHER'S NAME <u>Jacob Spielman</u>   |                               | 14. MOTHER'S MAIDEN NAME <u>Mary Joseph Phine</u>  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Unknown</u>  |                               | 16. SOCIAL SECURITY NO. <u>UNKNOWN</u>   |                                  |
| 17. INFORMANT <u>Patents Clerk</u>  |                               | Address  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Pneumonia</u><br>DUE TO (b) <u>Arterio-sclerotic vascular disease</u><br>DUE TO (c) <u></u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                               | INTERVAL BETWEEN ONSET AND DEATH   |                                  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                               | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                               | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)   |                                  |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                               | 20f. (City or town) (County) (State)   |                                  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 30th</u> , 19 <u>66</u> , to <u>Jan 15th</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 15th</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.                  |                               |  |                                  |
| 22a. SIGNATURE <u>M. Labele MacGregor</u>   |                               | 22b. DATE SIGNED <u>1-15-67</u>  |                                  |
| 22c. PHYSICIAN'S NAME (Type) <u>MacGregor</u>   |                               | 22d. ADDRESS <u>Greater Baltimore Medical Center</u>   |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |                               | 23b. DATE THEREOF <u>1/18/67</u>   |                                  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>  |                               | 23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>   |                                  |
| 24. FUNERAL DIRECTOR <u>Robert H. Hargrave</u>  |                               | 25a. REC'D BY REGISTRAR <u>JAN 19 1967</u>   |                                  |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>  |                               | DATE   |                                  |

1. 10. 1944

FOR STATE  
HEALTH DEPT.

00434

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00437

|   |                                     |   |  |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |                                     | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Phoenix</b>                  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Phoenix</b>  |                                     | c. LENGTH OF STAY IN 1b<br><b>Hours</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Waren Road, 4 Mi. E. of York Road</b>  |                                     | d. STREET ADDRESS<br><b>3 Glenbrook Drive</b>   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>MILTON</b> Middle <b>T.</b> Last <b>SPILLERS</b>  |                                     | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>8</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b>    | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/21/24</b>   |
| 9. AGE (In years last birthday)<br><b>42</b> yrs.   |                                     | IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Meat Cutter</b>   |                                     | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD STORE</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Georgia</b>   |                                     | 12. CITIZENSHIP OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Claude Spillers</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Tula Rackley</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>Yes WW II</b>   |                                     | 16. SOCIAL SECURITY NO.<br><b>260-03-2152</b>   |  |
| 17. INFORMANT<br><b>Mrs. Velma T. Spillers</b>  |                                     | Address<br><b>3 Glenbrook Dr.</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a) <b>Cranio-cerebral Injuries</b><br>817.4 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }<br>(b) _____<br>(c) _____  |                                     |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                     |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH<br><b>Driver in auto-fixed object accident.</b>  |                                     | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour <b>1</b> m <b>7</b> p.m. <b>1967</b>   |                                     | 20d. PLACE OF INJURY (Home, farm, factory, street, office, etc.)<br><b>Street</b>   |  |
| 20e. (City or town)<br><b>Phoenix</b>   |                                     | (County) <b>Baltimore</b> (State) <b>Md.</b>  |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input type="checkbox"/> , <b>Accident</b> <input checked="" type="checkbox"/> , <b>Suicide</b> <input type="checkbox"/> , <b>Homicide</b> <input type="checkbox"/> , <b>Undetermined manner</b> <input type="checkbox"/> |                                     |   |  |
| ACTUAL SIGNATURE<br><b>Rudiger Breiteneker</b> M.D.   |                                     | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)<br><b>Rudiger Breiteneker, M.D.</b>  |                                     | ASS STANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |                                     | 22. DATE SIGNED<br><b>1/8/67</b>  |  |
| Address (Street, city, town, or county)   |                                     |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1/11/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Cockeysville, Md.</b>              |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Rd. 21204</b>   |                                     | 25. REC'D BY REGISTRAR<br><b>JAN 11 1967</b>  |  |
| 26. REGISTRY SIGNATURE<br><b>Judge</b>  |                                     |   |  |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00435

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00438

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>             |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODLAWN</b>  |  |   |  | c. LENGTH OF STAY N 1b <b>6 YRS</b>  |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2013 KERNAN DRIVE</b>   |  |   |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| 3. NAME OF DECEASED (Type or print) <b>EDNA VERL STAUFFER</b>   |  |   |  | 4. DATE OF DEATH <b>JAN 1 19 67</b>  |  |   |  |
| 5. SEX <b>FEMALE</b>  |  | 6. COLOR OR RACE <b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <b>APR 9, 1890</b>   |  |
| 9. AGE (in years last birthday) <b>76</b> yrs   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b> |  | 11. BIRTHPLACE (State or foreign country) <b>DANIELS MD</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>JOHN ENGLE</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME <b>SOPHIE ? (UNKNOWN)</b>   |  |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>   |  |   |  | 16. SOCIAL SECURITY NO <b>219014967</b>  |  | 17. INFORMANT <b>MRS WILLIAM LINE</b> Address <b>SAME ADDRESS</b>                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ARTEROSCLEROTIC HEART DISEASE</b><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>CEREBRAL THROMBOSIS</b> DUE TO<br>(c) <b>1 MON.</b>  |  |   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   |  |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18)   |  |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>      |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John N. Snyder</b> M.D.   |  |   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
| EXAMINER'S NAME (Type) <b>JOHN N. SNYDER</b>  |  |   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |  |
|   |  |   |  | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |  |
|   |  |   |  | Address (Street, city, town, or county) <b>6348 FREDERICK RD.</b>  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   |  | 23b. DATE THEREOF <b>1-4-1967</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>  |  | 23d. LOCATION (City or town) (County) (State) <b>Howard Co. Md.</b>                 |  |
| 24. FUNERAL DIRECTOR <b>G. Foward Strong 3207 W. North Ave.,</b>  |  |   |  | 25a. REC'D BY REGISTRAR <b>JAN 4 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>                                     |  |





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00436

00439

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |                                    |  |   |  |   |
|--|------------------------------------|--|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |                                    |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>11</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pikesville</b>  |                                    | c. LENGTH OF STAY IN 1b  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Pikesville</b> 03 1 |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>1 Mellinee Avenue</b>   |                                    |  | d. STREET ADDRESS<br><b>7118 Walnut Avenue</b>  |  | e. RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>               |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>LAURA GEORGIA ANN STEPNEY</b>  |                                    |  | 4 DATE OF DEATH<br>Month Day Year<br><b>January 25, 1967</b>  |  |   |
| 5 SEX<br><b>Female</b>   | 6 COLOR OR RACE<br><b>Negro</b>    | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>2/22/1891</b>   | 9 AGE (in years last birthday)<br><b>75</b> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic Work</b>  |                                    | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Private Family</b>   |   | 11 BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                    |  | 13. FATHER'S NAME<br><b>William Whiten</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Georgianna Whiten</b>   |                                    |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>                |  |   |
| 16. SOCIAL SECURITY NO.  |                                    |  | 17. INFORMANT Address<br><b>Mrs Lillian Hall 7118 Walnut La. PKS. Md.</b>   |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br>4200 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)  |                                    |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |                                    |  |   |  | 19. WAS A TUPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                                    | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                    | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |                                    |  |   |  |   |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b> M.D.   |                                    | 22. DATE SIGNED<br><b>January 26, 1967</b>   |   | 22. DATE SIGNED  |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |                                    | Address (Street, city, town, or county)  |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>130/67</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Saint Thomas Cem</b>  |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Randallstown Md.</b>                                   |   |
| 24. FUNERAL DIRECTOR<br><b>Herbert E. Nutter 3035 W. North Ave. Balt.</b>  |                                    | 25a. REC'D BY REGISTRAR<br><b>JAN 31 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>James Judge</b>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
28 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                                  |   |   |   |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
|---|--|----------------------------------|---|---|---|--|---|---|--|--|--|----------------------------------|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  |  |                                  |   |   |   |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 00437   |  |                                  |   |   | CERTIFICATE OF DEATH  |  |   |   |  | 00440  |  |                                  |  |  |  |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY _____ |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |                                  | c. LENGTH OF STAY IN 1b<br><b>6 Mo.</b> |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore</b>                              |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Ridgeway Manor Home</b>  |  |                                  |   |   | d. STREET ADDRESS<br><b>4626 Manordene Rd.</b>  |  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |                                  |  |  |  |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <b>JULIA BROTHERTON STEVENS</b>  |  |                                  |   |   | First Middle Last   |  | 4. DATE OF DEATH<br><b>January 19, 1967</b> |   |  | Month Day Year   |  |                                  |  |  |  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>July 3, 1873</b>                                |   | 9. AGE (In years last birthday)<br><b>93 yrs</b>  |  | 10. IF UNDER 1 YEAR<br>Months Days   |  | 11. IF UNDER 24 HRS<br>Hours Min |  |  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |                                  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b> |   |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |                                  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Morris Cole Brotherton</b>  |  |                                  |   |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Sarah Moore Mattingly</b>               |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |                                  |   | 16. SOCIAL SECURITY NO.<br><b>218-22-4254</b>   |   | 17. INFORMANT<br><b>Mrs. Sarah S. Duffy</b>                            |   |   |  | Address<br><b>Same</b>   |  |                                  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY<br><b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b><br>DUE TO (b) <b>Arteriosclerosis</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ |  |                                  |   |   |   |  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>years</b>                                       |  |                                  |  |  |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |                                  |   |   |   |  |   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |                                  |  |  |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |                                  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour o.m. p.m. <b>19</b>  |  |                                  |   | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)  |  |  |  |                                  |  |  |  |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan 15, 1950</b> to <b>Jan 19, 1967</b> that (I) <del>was</del> lost saw the deceased alive on <b>Jan 19, 1967</b> and that death occurred at <b>7 P.M.</b> from causes and on the date stated above.  |  |                                  |   |   |   |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><b>C. Mendelis</b>  |  |                                  |   | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |   | 22b. DATE SIGNED<br><b>1-21-67</b>                                     |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Dr. Christopher Mendelis</b>   |  |                                  |   | 22d. ADDRESS<br><b>2308 Edmondson Ave.</b>  |   |  |   |   |  |  |  |                                  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                                  |   | 23b. DATE THEREOF<br><b>1-23-67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Olivet</b>                |   | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Md.</b>                            |  |  |  |                                  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br><b>Mitchell-Wiedefeld Home, Inc.</b>  |  |                                  |   | ADDRESS<br><b>6500 York Rd. Baltimore, Md. 21212</b>  |   | 25a. REC'D BY REGISTRAR<br><b>JAN 25 1967</b>                          |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |  |  |                                  |  |  |  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, printers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |  |   |  |  |  |   |                              |  |
|--|--|--|---|--|--|--|---|------------------------------|--|
| 00438  |  |  |   |  | 00441  |  |   |                              |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE MARYLAND</u><br>c. LENGTH OF STAY IN lb <u>69 YEARS</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>   |  |  |   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>BALTIMORE</u> b. COUNTY <u>MARYLAND</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MARYLAND</u><br>d. STREET ADDRESS <u>1345 HERKIMER ST 3316 LAKE AVENUE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |                              |  |
| 3. NAME OF DECEASED (Type or print) <u>ROSALIE D. STIEGMANN</u><br>First Middle Last   |  |  | 4. DATE OF DEATH <u>January - 23 19 67</u><br>Month Day Year  |  | 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9-28-97</u> 9. AGE (In years last birthday) <u>69 yrs.</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.   |  |   |                              |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>   |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MARYLAND</u>   |  |   | 12. CITIZEN OF WHAT COUNTRY? |  |
| 13. FATHER'S NAME <u>John Raymond DUFFY</u>  |  |  | 14. MOTHER'S MAIDEN NAME <u>MARY ROSA LEE DUFFY O'BRIEN</u>   |  |  |  |   |                              |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |  |  | 16. SOCIAL SECURITY NO. <u>218-01-5171</u>  |  | 17. INFORMANT <u>FAMILY - 3316 LAKE AVE.</u>   |  |   |                              |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>416X RHEUMATIC HEART DISEASE</u><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PULMONARY EMBOLI &amp; BRONCHOPNEUMONIA</u><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |   |  |  |  |   |                              |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |                              |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. 19 p.m.  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)                              |                              |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1-12</u> , 19 <u>67</u> , to <u>1-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> , 19 <u>67</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.  |  |  |   |  |  |  |   |                              |  |
| 22a. SIGNATURE <u>Evelyn L. Ramos M.D.</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>  |  |  |   |  | 22b. DATE SIGNED <u>1-23-67</u>  |  |   |                              |  |
| 22c. PHYSICIAN'S NAME (Type) <u>EVELYN L. RAMOS, M.D.</u>  |  |  |   |  | 22d. ADDRESS   |  |   |                              |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>  |  |  | 23b. DATE THEREOF <u>1-25-67</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE MEMORIAL</u>   |  | 23d. LOCATION (City, town or county) (State) <u>Howard Co. MD</u> |                              |  |
| 24. FUNERAL DIRECTOR <u>J. Walter Cook</u> ADDRESS <u>5444 BELAIR RD.</u>  |  |  |   |  | 25a. REC'D BY REGISTRAR <u>J. Charles Judge</u>  |  | 25b. REGISTRAR'S SIGNATURE  |                              |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

00439

CERTIFICATE OF DEATH

00442

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                     |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Middle River</u>   |   | c. LENGTH OF STAY IN 1b<br><u>13.1</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)<br><u>Ivy Hall Nursing Home</u>   |   | d. STREET ADDRESS<br><u>33 Cliffwood Rd.</u>   |   |
| 3 NAME OF DECEASED (Type or print)<br>First <u>Mignon</u> Middle <u>( )</u> Last <u>Stottlemeyer</u>  |   | 4 DATE OF DEATH<br>Month <u>January</u> Day <u>2</u> Year <u>1967</u>  |   |
| 5 SEX<br><u>Female</u>  | 6 COLOR OR RACE<br><u>white</u>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>April 16, 1891.</u>  |
| 9 AGE (In years)<br><u>75</u> yrs   |   | IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><u>housewife</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u></u>   |   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><u>Penna.</u>   |   | 12 CITIZEN OF WHAT COUNTRY? <u>USA</u>   |   |
| 13. FATHER'S NAME<br><u>John Carson</u>   |   | 14. MOTHER'S MAIDEN NAME<br><u>Loretta Adams</u>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>  |   | 16. SOCIAL SECURITY NO<br><u>217-03-1911DC</u>   |   |
| 17. INFORMANT<br><u>James Stottlemeyer</u>  |   | Address<br><u>Glen Run, Md.</u>  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>myocardial infarction</u><br>DUE TO <u>ASCVD</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <u></u><br>DUE TO <u></u><br>(c) <u></u> |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 yrs</u>  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u></u>  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><u></u>   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m. <u></u>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u></u>  | 20f. (City or town) (County) (State)<br><u></u>   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1966</u> , to <u>Jan 2, 1967</u> that (I) (we) last saw the deceased alive on <u>Jan 2, 1967</u> and that death occurred at <u>4:40 PM</u> from causes and on the date stated above  |   |  |   |
| 22a. SIGNATURE<br><u>G. M. Baumgardner M.D.</u>   |   | 22b. DATE SIGNED<br><u>1/3/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>G. M. Baumgardner</u>  |   | 22d. ADDRESS<br><u>12115 6</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>1/5/67.</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Moreland Memorial Cem.</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |
| 24. FUNERAL DIRECTOR<br><u>Leonard J. Ruck Inc Baltimore, Md.</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 5 1967</u>  |   |
|   |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   |

2000





00440

CERTIFICATE OF DEATH

00443

|  |   |   |   |
|--|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u><br>b. COUNTY <u>Baltimore</u>                    |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Rural - Randallstown</u>  |   | c. LENGTH OF STAY IN lb<br><u>4 Days</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Balto County Hospital</u>   |   | d. STREET ADDRESS<br><u>St Paul Ave</u>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First <u>Frank</u> Middle <u>E.</u> Last <u>Strehle</u>   |   | 4. DATE OF DEATH<br>Month <u>January</u> Day <u>26</u> Year <u>1967</u>   |   |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>W</u>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>9/6/1909</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Bus Contractor</u>   |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Transportation</u>  | 9. AGE (In years last birthday)<br><u>57 yrs</u>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Maryland</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>United States</u>  |   |
| 13. FATHER'S NAME<br><u>Jacob Strehle</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Elsie Telzman</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>050 12 1964</u>  |   |
| 17. INFORMANT<br><u>Mrs. Dorothy Strehle</u>   |   | Address<br><u>Abolstock, Md</u>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>Massive Pulmonary Embolism</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br><u>Phlebitis left lower extremity</u><br>DUE TO<br>(b)<br>(c) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>3 weeks</u>  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)<br><u>Injured while working</u>                                |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)<br><u>Home</u>   | 20f. (City or town) (County) (State)<br><u>Balto.</u>   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> , 19 <u>67</u> , to <u>1/26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>67</u> , and that death occurred at <u>5:21</u> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><u>Samuel J. Abrams</u>  |   | 22b. DATE SIGNED<br><u>1/26/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Samuel J. Abrams</u>  |   | 22d. ADDRESS<br><u>7220 Park Heights Ave</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1-28-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn Cemetery</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Balto.</u>                                    |
| 24. FUNERAL DIRECTOR<br><u>Arthur H. Houghton</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>1-22-1967</u>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

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VR A15 (4)  
20 M 1/66

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00441

CERTIFICATE OF DEATH

00444

|  |   |   |  |
|--|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALT. more Co</u> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>W. Baltimore</u>             |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>TOWSON</u>  |   | c. LENGTH OF STAY in 1b<br><u>23 years</u>  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Baltimore</u> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>AGED WOMENS &amp; AGED MENS Home</u>  |   | d. STREET ADDRESS<br><u>3452 Reswick Rd</u>   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <u>CHARLES</u> Middle <u>DENTON</u> Last <u>SULLIVAN</u>   |   | 4. DATE OF DEATH<br>Month <u>JAN</u> Day <u>17</u> Year <u>1967</u>   |  |
| 5. SEX<br><u>M</u>   | 6. COLOR OR RACE<br><u>WHITE</u>  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>JAN 1, 1876</u>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>CHAUFFEUR</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY   | 9. AGE (In years last birthday)<br><u>91</u> yrs.  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Westminster, Md</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>Jessie Sullivan</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Amelia Brown</u>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)   |   | 16. SOCIAL SECURITY NO.<br><u>219-12-9107A</u>  |  |
| 17. INFORMANT<br><u>Carol Sherman 645 Chestnut Ave</u>   |   | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <u>A.S.C.U.D.</u><br><u>Hx dx</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO<br>(c) _____ |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 min</u>   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 18</u> , 19 <u>44</u> , to <u>Jan. 17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Jan. 17</u> , 19 <u>67</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.          |   |   |  |
| 22a. SIGNATURE<br><u>Newland E. Day</u>  |   | 22b. DATE SIGNED<br><u>January 18, 1967</u>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Newland E. Day</u>  |   | 22d. ADDRESS<br><u>4-E-33rd St Baltimore Md</u>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   | 23b. DATE THEREOF<br><u>1-19-67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>KRIDER CEMETERY</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Westminster MARYLAND</u>                         |
| 24. FUNERAL DIRECTOR<br><u>Am. Cook-Brook's Towson Inc.</u>  |   | 25a. REC'D BY REGISTRAR<br><u>1650 YORK Rd. Towson, Md.</u>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>   |   | DATE <u>JAN 24 1967</u>   |  |



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VR A15 (4)  
20 M 1/

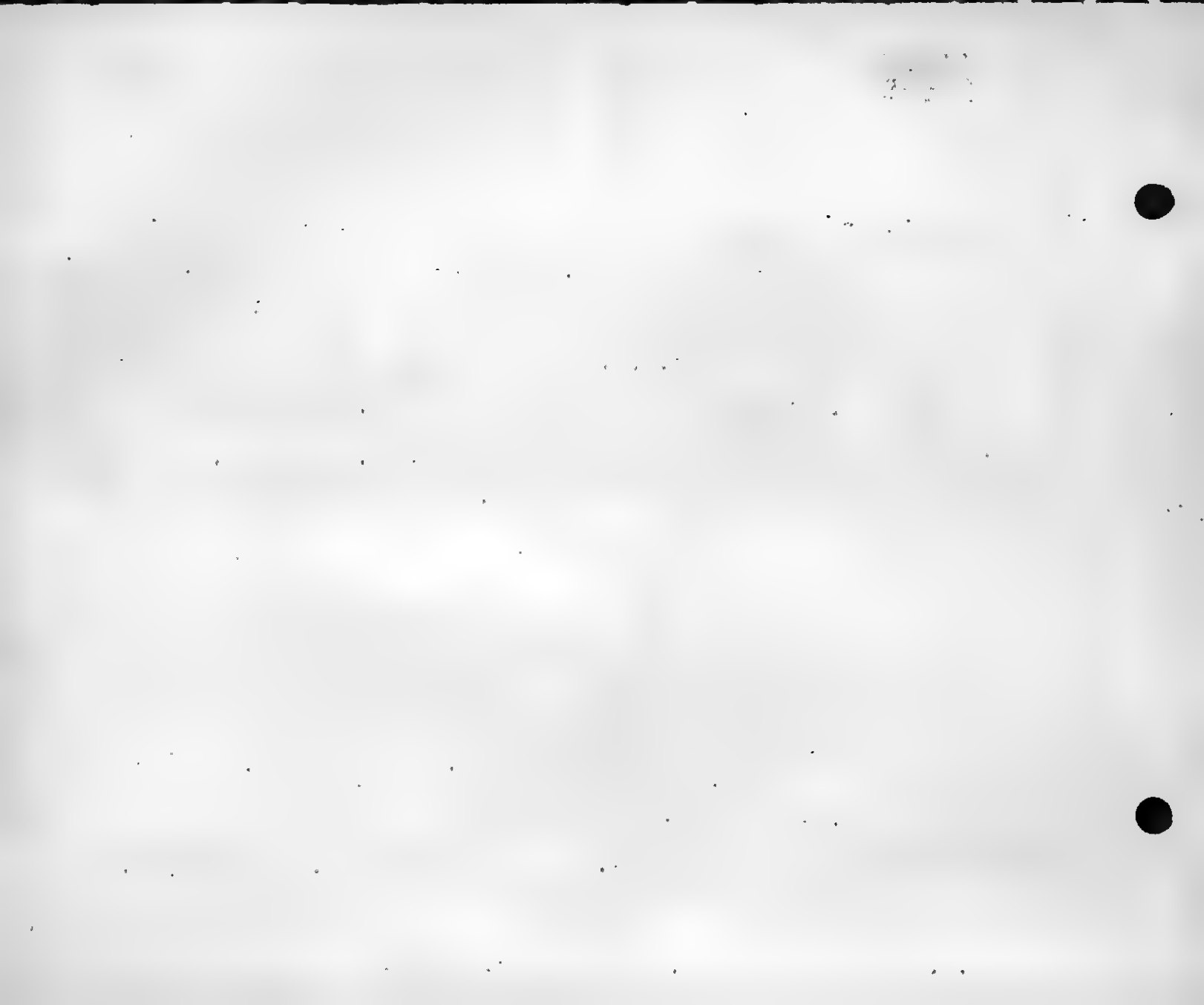
| <div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b><br/> <b>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</b><br/> <b>CERTIFICATE OF DEATH</b> </div>  |  |   |  |   |  |  |  |   |  |   |  |
|--|--|---|--|---|--|--|--|---|--|---|--|
| <b>00442</b>   |  |   |  |   |  | <b>00445</b>   |  |   |  |   |  |
| <b>1 PLACE OF DEATH</b><br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |  |   |  |   |  | <b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>   |  |   |  |   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  |   |  | c. LENGTH OF STAY IN 1b<br><b>47 DAYS</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE - 21231</b>   |  |   |  |   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |   |  |   |  | d. STREET ADDRESS<br><b>1906 BANK STREET</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| <b>3 NAME OF DECEASED</b><br>(Type or print) <b>(Ludwik) LOUIS</b> First <b>KASPER</b> Middle <b>SZYMANOSKI</b> Last   |  |   |  |   |  | <b>4. DATE OF DEATH</b><br>Month <b>JANUARY</b> Day <b>4</b> Year <b>19 67</b>   |  |   |  |   |  |
| <b>5 SEX</b><br><b>MALE</b>  |  | <b>6 COLOR OR RACE</b><br><b>WHITE</b>              |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | <b>8 DATE OF BIRTH</b><br><b>AUGUST 18, 1895</b>   |  | <b>9 AGE</b> (n years lost birthday) yrs. <b>71</b>                                       |  | <b>10. IF UNDER 1 YEAR</b><br>Months <b>4</b> Days <b>19</b> Hours <b>67</b> Min.                 |  |
| <b>10a. OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>   |  |   |  | <b>10b. KIND OF BUSINESS OR INDUSTRY</b><br><b>BALTIMORE CITY</b>   |  | <b>11 BIRTHPLACE</b> (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  |   | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b> |   |  |
| <b>13 FATHER'S NAME</b><br><b>FRANK SZYMANOSKI (Szymanowski)</b>   |  |   |  |   |  | <b>14. MOTHER'S M.A.DEN NAME</b><br><b>CECELIA PISARSKI</b>  |  |   |  |   |  |
| <b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b><br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |  | <b>16 SOCIAL SECURITY NO</b><br><b>213 30 72 24</b> |  | <b>17. INFORMANT</b><br>Address <b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |  |  |   |  |   |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CHOLELITHIASIS, INTERMITTENT COMMON DUCT OBSTRUCTION, ASCENDING INFECTION</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)                     |  |   |  |   |  |  |  |   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>UNKNOWN</b>   |  |
| <b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>  |  |   |  |   |  |  |  |   |  |   |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |  |   |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18)  |  |  |  |   |  |   |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |  |   |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  |  | <b>20f. (City or town) (County) (State)</b>   |  |   |  |
| <b>21 I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/18/66</b> , 19__ to <b>1/4/67</b> , 19__, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>1/4/67</b> , 19__, and that death occurred at <b>3:15 AM</b> , from causes and on the date stated above. |  |   |  |   |  |  |  |   |  |   |  |
| <b>22a. SIGNATURE</b><br><b>GEORGE C. MC ELPATRICK, M. D.</b>  |  |   |  |   |  | <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input checked="" type="checkbox"/> |  | <b>22b. DATE SIGNED</b><br><b>1/4/67</b>  |  |   |  |
| <b>22c. PHYSICIAN'S NAME (Type)</b>  |  |   |  |   |  | <b>22d. ADDRESS</b><br><b>VAH FORT HOWARD, MARYLAND</b>  |  |   |  |   |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b><br><b>BURIAL</b>  |  |   |  | <b>23b. DATE THEREOF</b><br><b>Jan. 7, 1967</b>   |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><b>HOLY ROSARY CEMETERY</b>   |  | <b>23d. LOCATION (City or Town) (County) (State)</b><br><b>BERMAN HILL RD. BALTO. MD.</b> |  |   |  |
| <b>24. FUNERAL DIRECTOR</b><br><b>Charles D. Sadowski</b>  |  |   |  |   |  | <b>ADDRESS</b><br><b>SADOWSKI FUNERAL HOME</b>   |  | <b>25. REC'D BY REGISTRAR</b><br><b>JAN 6 1967</b>  |  | <b>25b. REGISTRAR'S SIGNATURE</b><br><b>Charles Judge</b>   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                                  |   |   |  |                                    |  |  |                                  |
|--|--|----------------------------------|---|---|--|------------------------------------|--|--|----------------------------------|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                                  |   |   |  |                                    |  |  |                                  |
| 00443  |  |                                  |   |   | 00446  |                                    |  |  |                                  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  |                                  |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>1</b> |                                    |  |  |                                  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b>  |  |                                  | c. LENGTH OF STAY IN 1b   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 21212</b>                           |                                    |  |  |                                  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  |                                  |   |   | d. STREET ADDRESS<br><b>1103 E. Belvedere Ave/</b>   |                                    |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elmer</b> Middle <b>N.</b> Last <b>Taylor</b>  |  |                                  |   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>15</b> Year <b>1967</b>   |                                    |  |  |                                  |
| 5. SEX<br><b>Male</b>  |  | 6. COLOR OR RACE<br><b>White</b> |   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>1-27-98</b> |  | 9. AGE (In years last birthday)<br><b>68</b> yrs. IF UNDER 1 YEAR: Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min. IF UNDER 24 HRS. |                                  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Trainmaster</b>  |  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Pa.R.R.</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>   |                                    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                                  |
| 13. FATHER'S NAME<br><b>William B. Taylor</b>  |  |                                  |   |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary A. Fairborne</b>   |                                    |  |  |                                  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No</b>   |  |                                  | 16. SOCIAL SECURITY NO.<br><b>(If yes give war or dates of service)</b>                                   |   | 17. INFORMANT<br><b>Elizabeth C. Taylor</b>  |                                    |  | Address<br><b>Above</b>  |                                  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Ruptured aneurysm of abdominal aorta.</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis.</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |                                  |   |   |  |                                    |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |   |  |                                    |  |  |                                  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m.   |  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                    | 20f. (City or town) (County) (State)                                 |  |                                  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Jan. 15, 1967</b> to <b>Jan. 15, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Jan. 15, 1967</b> , and that death occurred at <b>9:35 PM</b> , from the causes and on the date stated above.   |  |                                  |   |   |  |                                    |  |  |                                  |
| 22a. SIGNATURE<br><b>M.S. Cockburn M.D.</b>  |  |                                  |   |   | 22b. DATE SIGNED<br><b>January 16, 1967</b>  |                                    |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                                  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>M.S. Cockburn, M.D.</b>   |  |                                  |   |   | 22d. ADDRESS<br><b>7620 York Rd., Baltimore, Md. 21204</b>   |                                    |  |  |                                  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |                                  | 23b. DATE THEREOF<br><b>1-19-67</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood</b>  |                                    | 23d. LOCATION (City, town or county) (State)<br><b>Parkville Md.</b> |  |                                  |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b>   |  |                                  |   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 14 1967</b>  |                                    | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Jones</b>                |  |                                  |





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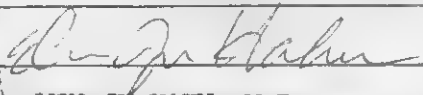

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00444

CERTIFICATE OF DEATH

00447

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY                                 |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |   | c. LENGTH OF STAY IN 1b<br><b>15 DAYS</b>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>2336 EDMONDSON AVENUE</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>ROBERT</b> Middle <b>- - -</b> Last <b>TAYLOR</b>   |   | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>29</b> Year <b>19 67</b>   |   |
| 5 SEX<br><b>MALE</b>  | 6 COLOR OR RACE<br><b>NEGRO</b>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>JUNE 14, 1897</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEELWORKER</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY  | 9 AGE (n years last birthday) yrs<br><b>69</b>  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>KING WILLIAM COUNTY, VA.</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |   |
| 13. FATHER'S NAME<br><b>GEORGE TAYLOR</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>PEACHIE</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW I</b>  |   | 16. SOCIAL SECURITY NO<br><b>212 01 92 09</b>  |   |
| 17. INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS</b>  |   | <b>FORT HOWARD, MARYLAND</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>PNEUMONIA</b><br>DUE TO<br>(b) <b>COR PULMONALE AND PULMONARY EMPHYSEMA</b><br>DUE TO<br>(c) <b>CONGESTIVE CARDIAC FAILURE</b>                                   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 DAYS</b><br><b>YEARS</b><br><b>MONTHS</b>                |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>JAN. 14</b> , 19 <b>67</b> , to <b>JAN. 29</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>JAN. 29</b> , 19 <b>67</b> , and that death occurred at <b>500P</b> M, from causes and on the date stated above. |   |  |   |
| 22a. SIGNATURE<br>   |   | 22b. DATE SIGNED<br><b>1-29-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>WON JU HAHN, M.D.</b>  |   | 22d. ADDRESS<br><b>VA HOSPITAL, FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>2-3-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                       |
| 24. FUNERAL DIRECTOR<br><b>EIROY O. WILSON</b>  |   | 25a. REC'D BY REGISTRAR<br><b>SCHROEDER AND BRANTLEY AVE., BALTIMORE, MD.</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br>   |   | DATE<br><b>FEB 1 1967</b>  |   |



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VR A15 (4)  
20 M 1/66

00445

CERTIFICATE OF DEATH

00448

|   |  |   |   |
|---|--|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Harford</b> ✓             |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  | c. LENGTH OF STAY IN 'b'<br><b>20 Days</b>  | c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Bel Air</b> |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Spring Grove State Hospital</b>  |  | d. STREET ADDRESS<br><b>Box 282 Route 2</b>   |   |
| 3 NAME OF DECEASED (Type or print)<br><b>Florence S. Thompson</b>   |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>2</b> Year <b>1967</b>  |   |
| 5 SEX<br><b>Female</b>  | 6 COLOR OR RACE<br><b>White</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. AGE (In years next birthday)<br><b>84 yrs</b>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   | 11 BIRTHPLACE (County & State, or foreign country)<br><b>Maryland</b>                             |
| 13. FATHER'S NAME<br><b>James S. ? Beale</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown Susan Wilgis</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO<br><b>None</b>   |   |
| 17. INFORMANT<br><b>Records: Spring Grove State Hospital</b>  |  | Address   |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malnutrition &amp; Dehydration</b><br>151X DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastric malignancy</b> DUE TO<br>(c) |  |   | INTERVA. BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)   |  |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Dec. 14, 1966</b> to <b>Jan. 2, 1967</b> , that (I) (we) last saw the deceased alive on <b>January 2, 1967</b> , and that death occurred at <b>12:20M</b> , from causes and on the date stated above.  |  |   |   |
| 22a. SIGNATURE<br><b>A. Jaheri</b>  |  | 22b. DATE SIGNED<br><b>January 2, 1967</b>  |   |
| 22c. PHYSICIAN'S NAME (Type) <b>Amanollah Jaheri</b>  |  | 22d. ADDRESS<br><b>Spring Grove State Hospital</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   | 23b. DATE THEREOF<br><b>1/4/67.</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Zion Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Jountain Green, Md.</b>                       |
| 24. FUNERAL DIRECTOR<br><b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 5 1967</b>   |   |
|   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |



## CERTIFICATE OF DEATH

Reg. Dist. No.

00446

00449

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>                      |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |  |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION<br><b>1523 Kirkwood Rd.</b>  |   | d. STREET ADDRESS<br><b>1523 Kirkwood Rd.</b>   |  |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Joseph W.</b> Middle <b>Tillen</b> Last   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>18</b> Year <b>19 67</b>   |  |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>Wh</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>2-11-96</b>                                     |
| 9. AGE (In years last birthday) <b>70</b> yrs   |   | IF UNDER 1 YEAR<br>Months Days Hours Min.   | IF UNDER 24 HRS<br>Hours Min.  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |   | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Late - Joseph Tillen</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>Late - Sarah</b>   |  |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)<br><input type="checkbox"/>  |   | 16. SOCIAL SECURITY NO.<br><b>212-03-0155</b>   |  |
| 17. INFORMANT<br><b>Mrs. Eva Tillen</b><br><b>1523 Kirkwood Rd.</b>   |   | Address   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>10511</b> DUE TO <b>Cancer of lung</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>                      |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a. m. p. m. <b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)                                   |
| 21. I certify that I attended the deceased from <b>July 3</b> , 19 <b>59</b> , to <b>Jan 18</b> , 19 <b>67</b> , that I last saw the deceased alive on <b>Jan 17</b> , 19 <b>67</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.<br>ADDRESS (Street, city or town, state) DATE SIGNED <b>1/19/67</b>  |   |   |  |
| ACTUAL SIGNATURE <b>Kennard Yaffe</b> M.D.  |   |   |  |
| PHYSICIAN'S NAME (Type) <b>Kennard Yaffe</b>  |   | <b>5501 Forest Park Ave.</b>  |  |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 22b. DATE THEREOF<br><b>1-23-67</b>   | 22c. NAME OF CEMETERY OR CREMATORY<br><b>Baltimore National Cem.</b>  | 22d. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |
| 23. FUNERAL DIRECTOR'S SIGNATURE<br><b>Witzke F. D. - 4101 Edmondson Ave.</b>   |   | 24a. REC'D BY REGISTRAR<br>DATE <b>19 1967</b>  |  |
|   |   | 24b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician on completely filled in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00447

## CERTIFICATE OF DEATH

00450

|  |   |   |   |
|--|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>                      |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)   |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Randallstown</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Balto. County General</u>   |   | d. STREET ADDRESS<br><u>3307 Offutt Rd.</u>   |   |
| 3. NAME OF DECEASED (Type or print) <u>Tillett, Frank</u>  |   | 4. DATE OF DEATH<br>Month <u>1</u> Day <u>17</u> Year <u>1967</u>   |   |
| 5. SEX <u>Male</u>   | 6. COLOR OR RACE <u>(W)</u>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH<br><u>March 7, 1897</u>  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Auto Mechanic</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Auto</u>  | 9. AGE (In years last birthday) <u>69</u> yrs                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><u>Charles Town, W. Va.</u>   |   | 12. CIT. ZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |   |
| 13. FATHER'S NAME<br><u>James Tillett</u>  |   | 14. MOTHER'S MAIDEN NAME<br><u>Fannie Williams</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>No</u>   |   | 16. SOCIAL SECURITY NO<br><u>218-05-7434</u>  | 17. INFORMANT<br><u>Mrs. Annie M. Tillett-3307 Offutt Rd.</u>                   |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Cardio-pulmonary Failure</u><br>DUE TO (b) <u>Senile Myocardium</u><br>DUE TO (c) <u>Adenocarcinoma squamous of uterus</u> |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>56</u>                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |   |   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12-20, 1966</u> , to <u>1-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-7-67</u> , and that death occurred at <u>2-4 PM</u> , from causes and on the date stated above.     |   |   |   |
| 22a. SIGNATURE<br><u>Dr. De Joya</u>   |   | 22b. DATE SIGNED<br><u>1/17/67</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)   |   | 22d. ADDRESS<br><u>Balto. County Gen. Hosp.</u>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>1/20/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Mt. Olive</u>  | 23d. LOCATION (City or Town) (County) (State)<br><u>Randallstown, Md. 21133</u> |
| 24. FUNERAL DIRECTOR<br><u>Loring Byers-8728 Liberty Rd. Randallstown</u>  |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 20 1967</u>  |   |
|  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





00448

## CERTIFICATE OF DEATH

00451

|   |                                  |   |                                   |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>                |                                   |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)<br><b>Owings Mills</b>  |                                  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Owings Mills</b>   |                                   |
| c. LENGTH OF STAY IN 1b<br><b>50 yrs.</b>   |                                  | d. STREET ADDRESS<br><b>121</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>Rosewood State Hospital</b>  |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>John Daniel Todd, Jr.</b>  |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>Jan. 2 19 67</b>   |                                   |
| 5. SEX<br><b>Male</b>   | 6. COLOR OR RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/8/04</b> |
| 9. AGE (In years last birthday)<br><b>62</b> yrs.   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                   |
| 10a. US. JAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Somerset - Maryland</b>   |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                                   |
| 13. FATHER'S NAME<br><b>John Daniel Todd</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>Maud E. Kelly</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no none none</b>  |                                  | 16. SOCIAL SECURITY NO<br><b>none</b>   |                                   |
| 17. INFORMANT<br><b>Records Rosewood State Hospital</b>   |                                  | Address   |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Possible malignancy, site unknown</b><br>DUE TO (b) <b>Cerebral Defect, Congenital</b><br>DUE TO (c) <b>Dyslexia</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |                                  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Birth</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Hydrocephalus, secondary</b>   |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                                  | 20f. (City or town) (County) (State)  |                                   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>4-3</b> , 19 <b>17</b> , to <b>1-2</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>1-2</b> 19 <b>67</b> , and that death occurred at <b>10:30 AM</b> , from causes and on the date stated above.  |                                  |   |                                   |
| 22a. SIGNATURE<br><b>Joyce M. Boyd</b>  |                                  | 22b. DATE SIGNED<br><b>1-2-67</b>   |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Joyce M. Boyd, M.D.</b>  |                                  | 22d. ADDRESS<br><b>Rosewood State Hospital, Owings Mills, Md.</b>   |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>CREMATION</b>   |                                  | 23b. DATE THEREOF<br><b>Jan. 5, 1967</b>  |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenmount Crematory</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore City, Md.</b>   |                                   |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook - Brooks Inc. 1217 St. Paul St.</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 6 1967</b>  |                                   |
|   |                                  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00449

00452

|   |                              |   |  |
|---|------------------------------|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <i>Baltimore</i>   |                              | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <i>Maryland</i> b. COUNTY _____   |  |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |                              | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><i>Towson Convalescent Home Chesapeake Cambridge Arms Apt</i>   |                              | d. STREET ADDRESS   |  |
| 3. NAME OF DECEASED<br>(Type or print)<br>First <i>Margaret</i> Middle <i>ANN</i> Last <i>Toner</i>   |                              | 4. DATE OF DEATH<br>Month <i>Jan.</i> Day <i>8</i> Year <i>1967</i>   |  |
| 5. SEX<br><i>Female</i>   | 6. COLOR OR RACE<br><i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><i>Jan 11 1882</i> |
| 9. AGE (In years last birthday)<br><i>84</i> yrs.   |                              | IF UNDER 1 YEAR<br>Months _____ Days _____  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Teacher - Homemaker</i>   |                              | 10b. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><i>A. A. Co., Md.</i>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  |
| 13. FATHER'S NAME<br><i>Albert Murphy</i>   |                              | 14. MOTHER'S MAIDEN NAME<br><i>Mary Herman</i>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)   |                              | 16. SOCIAL SECURITY NO. <i>216-46-3211</i>  |  |
| 17. INFORMANT: <i>Son (and T.C. Records)</i>  |                              | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Pneumonia</i><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b) <i>Chronic</i><br>(c) <i>Arteriosclerosis</i><br>DUE TO<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)<br><i>Chronic Arteriosclerosis</i> |  |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                              | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY<br>Month, Day, Year<br>Hour a.m. _____ p.m. _____   |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |                              | 20f. (City or town) _____ (County) _____ (State) _____  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <i>January 7, 1967</i> to <i>Jan 8, 1967</i> , that (I) (we) last saw the deceased alive on <i>Jan 7, 1967</i> , and that death occurred at <i>10:20 P</i> M, from the causes and on the date stated above. |                              |   |  |
| 22a. SIGNATURE<br><i>Lester A. Wall Jr</i>  |                              | 22b. DATE SIGNED<br><i>1/8/67</i>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><i>LESTER A. WALL JR</i>  |                              | 22d. ADDRESS<br><i>1039 St Paul St Baltimore Md</i>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                              | 23b. DATE THEREOF<br><i>1/11/1967</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Lorraine Park Cemetery Woodlawn, Balto. Co., Md.</i>   |                              | 23d. LOCATION (City, town or county) _____ (State) _____  |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE<br><i>Stewart &amp; Mowen Co., 108 W. North Av., City 1</i>  |                              | 25a. REC'D BY REGISTRAR<br><i>JAN 11 1967</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |                              |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH<br>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |  |  |  |   |  |  |  |  |
|---|--|--|--|--|---|--|--|--|--|
| 00450   |  |  |  |  | 00453   |  |  |  |  |
| 1. PLACE OF DEATH   |  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)             |  |  |  |  |
| a. COUNTY <u>Baltimore</u>  |  |  |  |  | a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>   |  |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>   |  |  |  |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> |  |  |  |  |
| c. LENGTH OF STAY IN 1b   |  |  |  |  | d. STREET ADDRESS <u>2918 E Pratt St</u>  |  |  |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>  |  |  |  |  | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |  |  |  |
| 3. NAME OF DECEASED (Type or print) <u>Dorothy Gertrude Trautner</u>  |  |  |  |  | 4. DATE OF DEATH <u>1/24/67</u>   |  |  |  |  |
| 5. SEX <u>F</u>   |  |  |  |  | 6. COLOR OR RACE <u>W</u>   |  |  |  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |  |  |  | 8. DATE OF BIRTH <u>1/24/08</u>   |  |  |  |  |
| 9. AGE (In years last birthday) <u>58</u> yrs.  |  |  |  |  | 10. IF UNDER 1 YEAR <u>2</u> Months <u>1</u> Days <u>19</u> Hours <u>67</u> Min.                  |  |  |  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>  |  |  |  |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>   |  |  |  |  |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>   |  |  |  |  | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>   |  |  |  |  |
| 13. FATHER'S NAME <u>Adam Andrew Trautner</u>   |  |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Feldman</u>   |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>  |  |  |  |  | 16. SOCIAL SECURITY NO. <u>214-40-7167</u>  |  |  |  |  |
| 17. INFORMANT <u>-</u>  |  |  |  |  | Address <u>-</u>  |  |  |  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1   |  |  |  |  |   |  |  |  |  |
| PART I. DEATH WAS CAUSED BY: <u>Metastatic Breast Carcinoma</u>   |  |  |  |  |   |  |  |  |  |
| 170X IMMEDIATE CAUSE (a) <u>170X</u> DUE TO   |  |  |  |  |   |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO   |  |  |  |  |   |  |  |  |  |
| (c) DUE TO  |  |  |  |  |   |  |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |  |  |  |  |   |  |  |  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |   |  |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  |  |   |  |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |   |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m.   |  |  |  |  |   |  |  |  |  |
| 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> Not While at work <input type="checkbox"/>   |  |  |  |  |   |  |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |  |  |  |   |  |  |  |  |
| 20f. (City or town) (County) (State)  |  |  |  |  |   |  |  |  |  |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Dec. 14</u> , 19 <u>66</u> , to <u>Jan. 2</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>Jan. 2</u> , 19 <u>67</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above. |  |  |  |  |   |  |  |  |  |
| 22a. SIGNATURE <u>S. M. OTEZIA, M.D.</u>  |  |  |  |  |   |  |  |  |  |
| 22b. DATE SIGNED <u>Jan. 2, 1967</u>  |  |  |  |  |   |  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>L. N. OTEZIA</u>  |  |  |  |  |   |  |  |  |  |
| 22d. ADDRESS <u>GBMC - Charles St. Balt. M.D.</u>   |  |  |  |  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |  |  |  |   |  |  |  |  |
| 23b. DATE THEREOF <u>1-5-67</u>   |  |  |  |  |   |  |  |  |  |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>  |  |  |  |  |   |  |  |  |  |
| 23d. LOCATION (City, town or county) (State) <u>Mel. Balto.</u>   |  |  |  |  |   |  |  |  |  |
| 24. FUNERAL DIRECTOR <u>Helma A. Hoffmann</u>   |  |  |  |  |   |  |  |  |  |
| 25a. REC'D BY REGISTRAR <u>3218 Hudson</u>  |  |  |  |  |   |  |  |  |  |
| 25b. REGISTRAR'S SIGNATURE <u>DATE JAN 4 1967</u>   |  |  |  |  |   |  |  |  |  |

بسم الله الرحمن الرحيم  
الحمد لله الذي هدانا لهذا  
ما كنا لنهتدي لولا أن هدانا الله  
والحمد لله رب العالمين  
الحمد لله الذي هدانا لهذا  
ما كنا لنهتدي لولا أن هدانا الله  
والحمد لله رب العالمين

الحمد لله الذي هدانا لهذا  
ما كنا لنهتدي لولا أن هدانا الله  
والحمد لله رب العالمين

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SISTER GERARD

MARYLAND STATE DEPARTMENT OF HEALTH

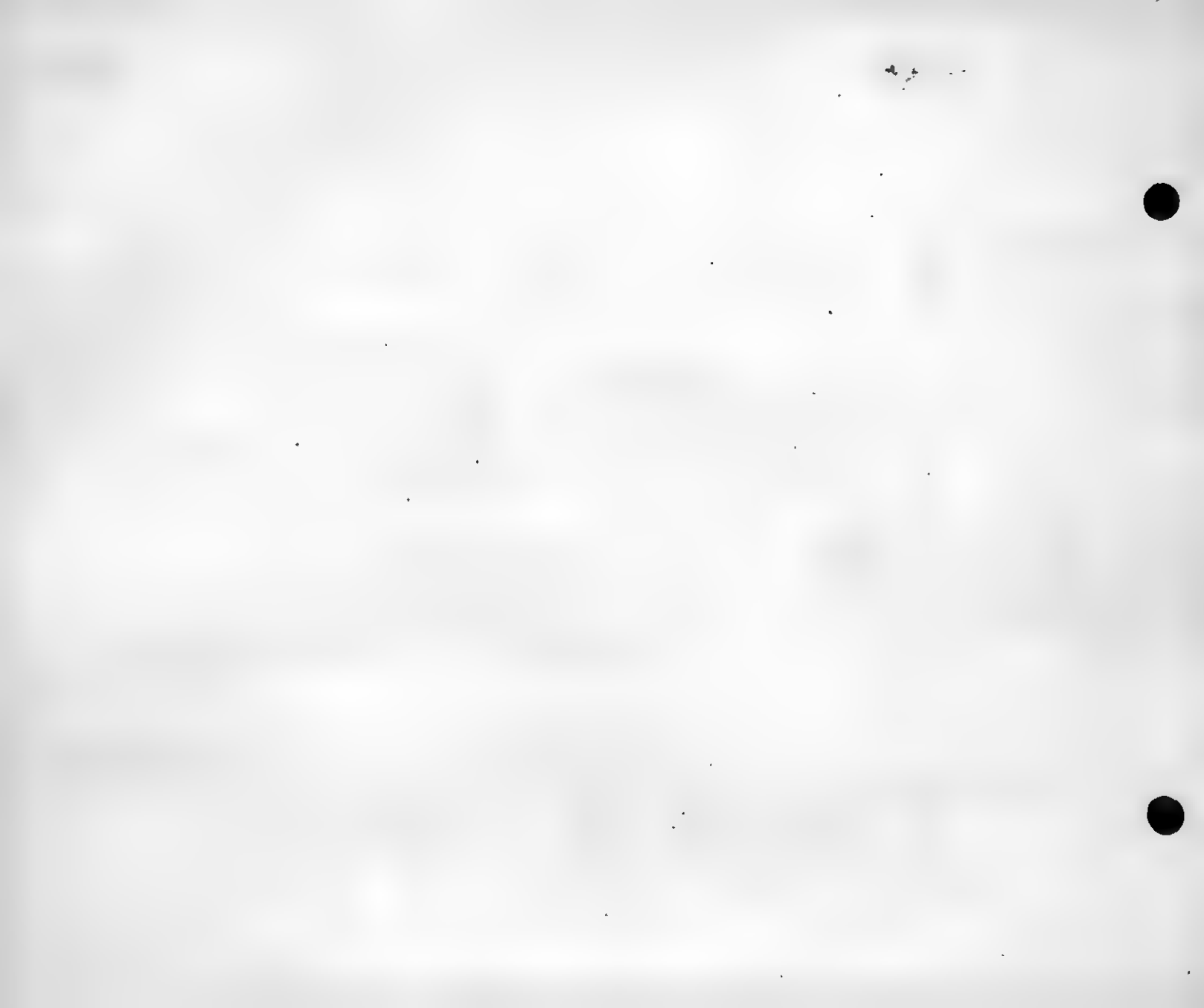
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00451

CERTIFICATE OF DEATH

00454

|  |                              |   |   |  |   |  |   |
|--|------------------------------|---|---|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                              |   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> |   |  |   |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>MARRIOTTSVILLE</b>  |                              |   |   | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)<br><b>MARRIOTTSVILLE</b>                            |   |  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)<br><b>BONSECOURS PROVINCIAL HOUSE</b>   |                              |   |   | e. STREET ADDRESS<br><b>MARRIOTTSVILLE, MD.</b>  |   |  |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>SISTER GERARD MAJELLA TREACY</b>  |                              |   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JAN. 11 1967</b>  |   |  |   |
| 5. SEX<br><b>F</b>   | 6. COLOR OR RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>JULY 2, 1884</b> |  | 9. AGE (In years last birthday)<br><b>82 yrs.</b> |  | IF UNDER 1 YEAR<br>Months Days Hours Min.   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NURSE</b>  |                              | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>RELIGIOUS</b>   |   | 11. BIRTHPLACE (County & State, or foreign country)<br><b>IRELAND</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>              |   |
| 13. FATHER'S NAME<br><b>EDMUND TREACY</b>  |                              |   |   | 14. MOTHER'S MAIDEN NAME<br><b>NORA RYAN</b>   |   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)  |                              | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br>Address<br><b>Mother Mary Alice - Bonsecours Sisters</b>  |   |  |   |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b><br><b>490X</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br>(c) |                              |   |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>7 DAYS</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |                              |   |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                              | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)                            |   |  |   |  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>  |                              | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>               |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |   | 20f. (City or town) (County) (State)                       |   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>1965</b> , 19 to <b>1/13</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>1/10/67</b> , 19 and that death occurred at <b>4:57 PM</b> , from the causes and on the date stated above.                              |                              |   |   |  |   |  |   |
| 22a. SIGNATURE<br><b>Harold W. Lipp, M.D.</b>  |                              |   |   | 22b. DATE SIGNED<br><b>1/14/67</b>   |   | 22c. PHYSICIAN'S NAME (Type)<br><b>4804 FREDERICK BLVD</b> |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)  |                              | 23b. DATE THEREOF   |   | 23c. NAME OF CEMETERY OR CREMATORY   |   | 23d. LOCATION (City, town or county) (State)               |   |
| <b>Burial</b>  |                              | <b>1-16-67</b>  |   | <b>Catholic Cem.</b>   |   | <b>Balto. Md.</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>Farley-Cavanaugh J.H.</b>   |                              |   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 13 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>         |   |





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00452

## CERTIFICATE OF DEATH

00455

|  |                                 |  |                                   |
|--|---------------------------------|--|-----------------------------------|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |                                 | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b>        |                                   |
| c. LENGTH OF STAY IN 1b<br><b>58 DAYS</b>  |                                 | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b>   |                                   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                 | d. STREET ADDRESS<br><b>2811 DELAWARE AVENUE</b>   |                                   |
| 3 NAME OF DECEASED (Type or print)<br>First<br><b>ARTHUR</b><br>Middle<br><b>ELMER</b><br>Last<br><b>TRIPP</b>   |                                 | 4. DATE OF DEATH<br>Month<br><b>JANUARY</b><br>Day<br><b>4</b><br>Year<br><b>19 67</b>   |                                   |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b> | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>3/17/05</b> |
| 9. AGE (In years last birthday)<br><b>61</b> yrs   |                                 | 10. IF UNDER 1 YEAR<br>Months Days Hours Min   |                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work on life, even if retired)<br><b>ATTENDANT</b>  |                                 | 10b. KIND OF BUSINESS OR INDUSTRY  |                                   |
| 11 BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |                                 | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                   |
| 13. FATHER'S NAME<br><b>EVERHART TRIPP</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>ROSA WEBER</b>  |                                   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWII</b>   |                                 | 16. SOCIAL SECURITY NO<br><b>219 10 75 82</b>  |                                   |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND</b>  |                                 | Address  |                                   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>356.1 ASPIRATION PNEUMONIA</b><br>DUE TO<br>(b)<br><b>AMYOTROPHIC LATERAL SCLEROSIS</b><br>DUE TO<br>(c)   |                                 | INTERVAL BETWEEN ONSET AND DEATH<br><b>DAYS</b><br><b>YEARS</b>  |                                   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>CHRONIC BRONCHITIS</b>   |                                 | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                 | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |                                   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                 | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                   |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                 | 20f. (City or town) (County) (State)   |                                   |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11/7/66</b> , 19__, to <b>1/4/67</b> , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/4/67</b> , 19__, and that death occurred at <b>5:40 PM</b> from causes and on the date stated above. |                                 |  |                                   |
| 22a. SIGNATURE<br><i>Carmelita A. Cendana</i>  |                                 | 22b. DATE SIGNED<br><b>1/4/66</b>  |                                   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>CARMELITA A. CENDANA, M. D.</b>   |                                 | 22d. ADDRESS<br><b>VAH FORT HOWA RD, MARYLAND</b>  |                                   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                 | 23b. DATE THEREOF<br><b>1/9/67</b>   |                                   |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>  |                                 | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>  |                                   |
| 24. FUNERAL DIRECTOR<br><b>MC CULLY FUNERAL HOME</b>   |                                 | 25a. REC'D BY REGISTRAR<br><b>JAN 6 1967</b>   |                                   |
| 25b. REGISTRAR'S SIGNATURE<br><i>Montes Judge</i>  |                                 | 25c. DATE<br><b>1/11/67</b>  |                                   |

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



00453

CERTIFICATE OF DEATH

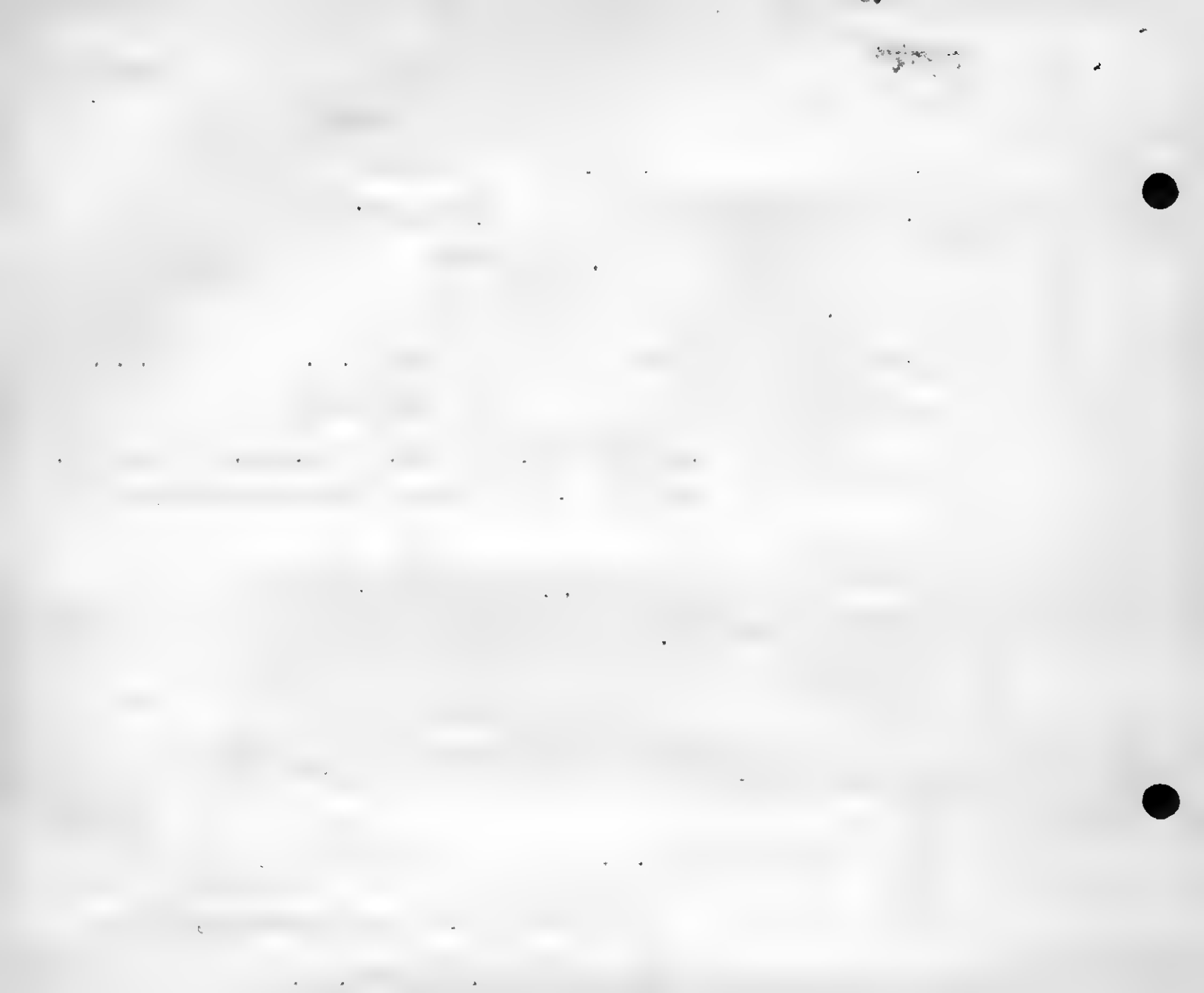
00456

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

M

|  |                                  |   |                                    |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>MARYLAND  |                                  | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY                                |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>172 DAYS</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp'tal, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |                                  | e. STREET ADDRESS <b>3302 CLARKS LANE, APT</b><br><b>1009 HARBOR BLVD</b>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First <b>BARNEY</b> Middle <b>S.</b> Last <b>TUCKER</b>   |                                  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>17</b> Year <b>19 67</b>  |                                    |
| 5. SEX<br><b>MALE</b>  | 6. COLOR OR RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    | 8. DATE OF BIRTH<br><b>9/11/06</b> |
| 9. AGE (In years last birthday) yrs. <b>60</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>WATCHMAKER</b>   |                                  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>JEWELRY STORE</b>   |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>NEW YORK, N. Y.</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                                    |
| 13. FATHER'S NAME<br><b>HYMAN TUCKER</b>   |                                  | 14. MOTHER'S MAIDEN NAME<br><b>IDA HOROWITZ</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |                                  | 16. SOCIAL SECURITY NO.<br><b>218 22 59 63</b>  |                                    |
| 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL. FT HOWARD, MD.</b>   |                                  | Address   |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>RIGHT LOWER LOBE PNEUMONIA, UNDETERMINED ORGANISM</b><br>DUE TO (b) <b>BRAIN TUMOR, LEFT CEREBAL, UNCLASSIFIED TYPE</b><br>DUE TO (c) <b>BRAIN TUMOR, LEFT CEREBAL, UNCLASSIFIED TYPE</b> |                                  | INTERVAL BETWEEN ONSET AND DEATH  |                                    |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>RUPTURE OF MID ESOPHAGUS. BENIGN PROSTATIC HYPERTROPHY</b>  |                                  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> at work <input type="checkbox"/> hot While <input type="checkbox"/> at work <input type="checkbox"/> |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |                                  | 20f. (City or town) (County) (State)  |                                    |
| 21. I certify that (this hospital) attended the deceased from <b>7/29/66</b> , 19 <b>67</b> , to <b>1/17/67</b> , 19 <b>67</b> , that (we) last saw the deceased alive on <b>1/17/67</b> , 19 <b>67</b> , and that death occurred at <b>10:15AM</b> , from causes and on the date stated above.                          |                                  |   |                                    |
| 22a. SIGNATURE<br><i>Neilson Neilson</i>   |                                  | 22b. DATE SIGNED<br><b>1/18/67</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>NEILSON NEILSON, M. D.</b>  |                                  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                                  | 23b. DATE THEREOF<br><b>1/19/67</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Maryland Free State Jewish War Veterans Cemetery Rosedale, Maryland</b>   |                                  | 23d. LOCATION (City or Town) (County) (State)   |                                    |
| 24. FUNERAL DIRECTOR<br><b>Sol Levinson &amp; Sons</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>JAN 23 1967</b>   |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |                                  | 25c. REGISTRAR'S NAME<br><b>Registerstown Rd. Baltimore, Md.</b>  |                                    |



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
3500 4-64

| MARYLAND STATE DEPARTMENT OF HEALTH  |  |                               |  |   |   |   |   |   |   |  |
|--|--|-------------------------------|--|---|---|---|---|---|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND   |  |                               |  |   |   |   |   |   |   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                               |  |   | 00457   |   |   |   |   |  |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b><br>c. LENGTH OF STAY IN 1b <b>20 years</b><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2499 1/2 Fairway</b>  |  |                               |  |   | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Dundalk 21222</b><br>d. STREET ADDRESS <b>2499 1/2 Fairway</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |   |   |   |  |
| 3. NAME OF DECEASED (Type or print) <b>EDMUND HARWOOD TURNER</b>   |  |                               |  |   | 4. DATE OF DEATH <b>January 14th 1967</b>   |   |   |   |   |  |
| 5. SEX <b>male</b>   |  | 6. COLOR OR RACE <b>white</b> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH <b>May 19, 1923</b>                      |   | 9. AGE (in years last birthday) <b>43 yrs.</b> IF UNDER 1 YEAR Months Days Hours Min. |   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill Wright</b>   |  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>Tel. Mfr.</b>   |   |   | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |   |  |
| 13. FATHER'S NAME <b>George G. Turner</b>  |  |                               |  |   | 14. MOTHER'S MAIDEN NAME <b>Emma K. Knoblo</b>  |   |   |   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WWII-Korea</b>   |  |                               |  |   | 16. SOCIAL SECURITY NO. <b>219-1804845</b>  |   |   |   |   |  |
| 17. INFORMANT <b>Loretta H. Turner, same as #2</b>   |  |                               |  |   | Address   |   |   |   |   |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>420.1</b><br>DUE TO (c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Obesity</b> |  |                               |  |   |   |   |   |   |   |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |                               |  |   |   |   |   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>   |  |                               |  |   |   |   |   |   |   |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |  |                               |  |   |   |   |   |   |   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |  |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |   | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)                        |   |   |  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>     |  |                               |  |   |   |   |   |   |   |  |
| ACTUAL SIGNATURE <b>Theodore C. Patterson</b>  |  |                               |  |   | 22. DATE SIGNED <b>1/14/67</b>  |   |   |   |   |  |
| EXAMINER'S NAME (Type) <b>Theodore C. Patterson, M.D.</b>  |  |                               |  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>   |   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  |                               |  |   | 23b. DATE THEREOF <b>1/18/67</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b> |   | 23d. LOCATION (City, town or county) (State) <b>Baltimore Co., Maryland</b> |  |
| 24. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc., Dundalk, Md.</b>  |  |                               |  |   | 25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>  |   | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>             |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                  |  |  |  |   |  |  |                              |                                  |  |
|---|--|------------------|--|--|--|---|--|--|------------------------------|----------------------------------|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 00455   |  |                  |  |  |  | 00458   |  |  |                              |                                  |  |
| 1. PLACE OF DEATH   |  |                  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) |  |  |                              |                                  |  |
| a. COUNTY   |  |                  | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) |  |  | a. STATE  |  |  | b. COUNTY                    |                                  |  |
| Baltimore   |  |                  | Randalstown  |  |  | Md  |  |  | Baltimore                    |                                  |  |
| c. LENGTH OF STAY IN 1b   |  |                  | d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)     |  |  | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)      |  |  | d. STREET ADDRESS            |                                  |  |
| 1 1/2 hrs.  |  |                  | Baltimore County General   |  |  | Balt.   |  |  | 6628 Sanzo Rd.               |                                  |  |
| 3. NAME OF DECEASED (Type or print)   |  |                  |  |  |  | 4. DATE OF DEATH  |  |  |                              |                                  |  |
| First Middle Last   |  |                  |  |  |  | Month Day Year  |  |  |                              |                                  |  |
| MILTON UHLFELDER  |  |                  |  |  |  | JAN 29 1967   |  |  |                              |                                  |  |
| 5. SEX  |  | 6. COLOR OR RACE |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH  |  | 9. AGE (In years last birthday)              |                              | IF UNDER 1 YEAR IF UNDER 24 HRS. |  |
| M   |  | W                |  |  |  | 6-27-04   |  | 62 yrs.                                      |                              | Months Days Hours Min.           |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                  |  | 10b. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (County & State, or foreign country)                                   |  |  | 12. CITIZEN OF WHAT COUNTRY? |                                  |  |
| Insurance salesman  |  |                  |  | Insurance  |  | Baltimore, Maryland   |  |  | USA                          |                                  |  |
| 13. FATHER'S NAME   |  |                  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |                              |                                  |  |
| David Uhlfelder   |  |                  |  |  |  | Rosa ?  |  |  |                              |                                  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)   |  |                  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT Address   |  |  |                              |                                  |  |
| No  |  |                  |  | 215-24-6426  |  | Mrs. Sara Uhlfelder, 6628 Sanzo Rd.   |  |  |                              |                                  |  |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>one year</u>  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 20c. TIME OF INJURY Month, Day, Year  |  |                  |  | 20d. INJURY OCCURRED   |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)                |  | 20f. (City or town) (County) (State)         |                              |                                  |  |
| Hour a.m. p.m. 19   |  |                  |  | While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |   |  |  |                              |                                  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Mar 1946</u> to <u>Jan 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 29, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above. |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22a. SIGNATURE  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22b. DATE SIGNED  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22c. PHYSICIAN'S NAME (Type)  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22d. ADDRESS  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22e. REC'D BY REGISTRAR   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 22f. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)   |  |                  |  | 23b. DATE THEREOF  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION (City, town or county) (State) |                              |                                  |  |
| Burial  |  |                  |  | 1/30/67  |  | Baltimore Hebrew  |  | Baltimore, Maryland                          |                              |                                  |  |
| 24. FUNERAL DIRECTOR  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 25a. REC'D BY REGISTRAR   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 25b. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 25c. DATE   |  |                  |  |  |  |   |  |  |                              |                                  |  |
| 25d. REGISTRAR'S SIGNATURE  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| Sol Levinson & Bros. Inc., 6010 Reisterstown  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| FEB 2 1967  |  |                  |  |  |  |   |  |  |                              |                                  |  |
| Charles Judge   |  |                  |  |  |  |   |  |  |                              |                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

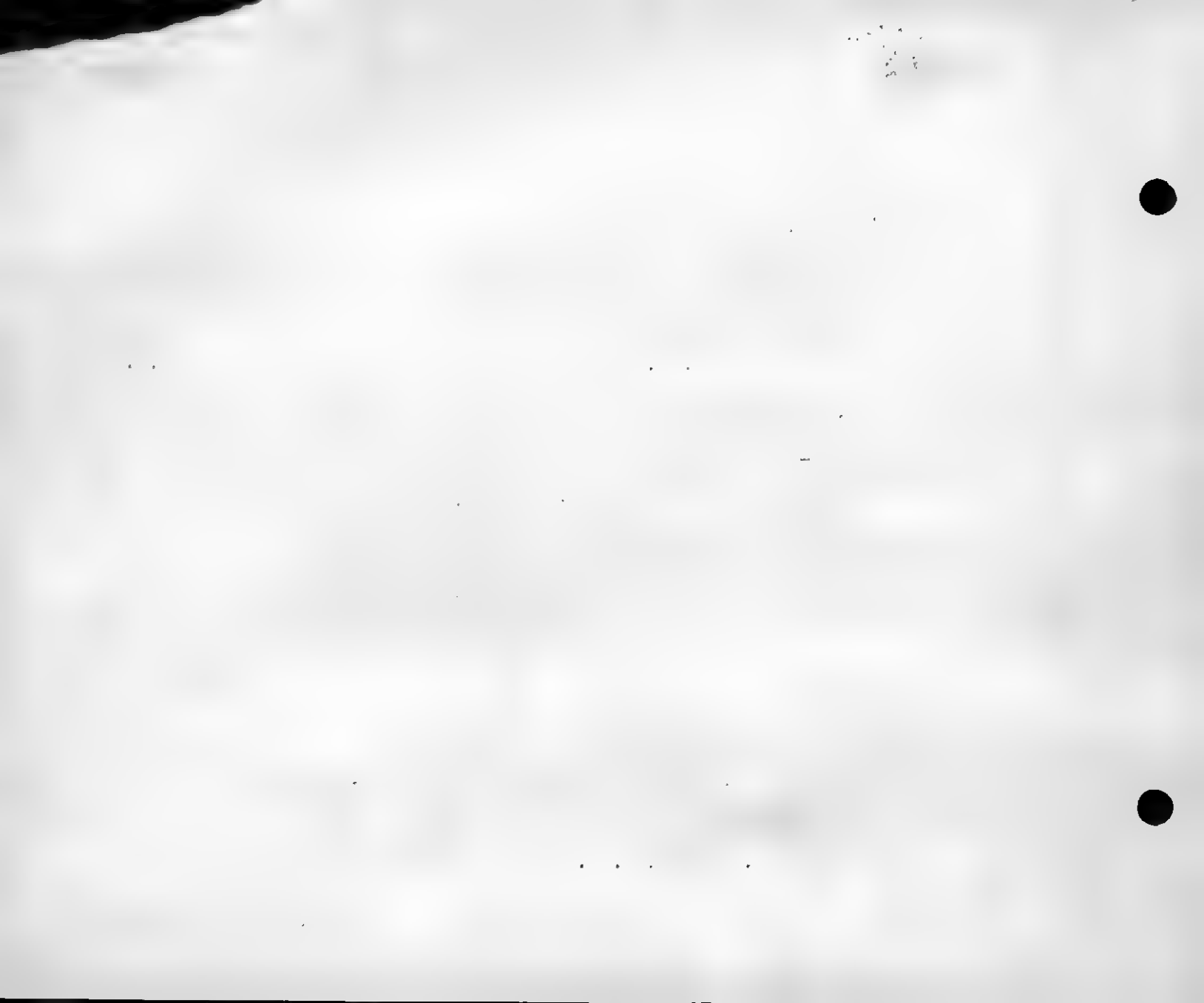
Item 23b film 4502 1/31/67 ml

00456

CERTIFICATE OF DEATH

00459

|   |   |   |   |
|---|---|---|---|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>MARYLAND   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>WICOMICO</b>         |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |   | c. LENGTH OF STAY IN 1b<br><b>38 DAYS</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>   |   | d. STREET ADDRESS<br><b>MAIN STREET</b>   |   |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>HARRY INGOLF VALENTINE</b>   |   | 4. DATE OF DEATH<br>Month Day Year<br><b>JANUARY 23 1967</b>  |   |
| 5. SEX<br><b>MALE</b>   | 6. COLOR OR RACE<br><b>WHITE</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>9/25/12</b>  |
| 9. AGE (In years last birthday)<br><b>54</b> yrs  |   | 10. IF UNDER 1 YEAR<br>Months Days Hours Min  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>RETIRED SOLDIER</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. ARMY</b>  |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>GRASS RANGE, MONTANA</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |   |
| 13. FATHER'S NAME<br><b>RICHARD E. VALENTINE</b>  |   | 14. MOTHER'S MAIDEN NAME<br><b>AGNES RASMUSSEN</b>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES 1955 - 1960</b>   |   | 16. SOCIAL SECURITY NO<br><b>577 28 99 08</b>   |   |
| 17. INFORMANT<br><b>CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND</b>   |   | Address   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY.<br>IMMEDIATE CAUSE (a)<br><b>420.1</b><br>DUE TO<br><b>INFARCTION OF MYOCARDIUM</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO<br><b>THROMBOSIS OF CORONARY ARTERIES</b><br>(c)<br>DUE TO<br><b>ARTERIOSCLEROTIC HEART DISEASE</b> |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>RECENT</b><br><b>UNKNOWN</b><br><b>UNKNOWN</b>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (X) (this hospital) attended the deceased from <b>12/16/66</b> , 19__ to <b>1/23/67</b> , 19__, that (1) (we) last saw the deceased alive on <b>1/23/67</b> , 19__, and that death occurred at <b>7:20A</b> M, from causes and on the date stated above.   |   |   |   |
| 22a. SIGNATURE<br><b>J. Fabara</b>  |   | 22b. DATE SIGNED<br><b>1/23/67</b>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JORGE A. FABARA, M. D.</b>   |   | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 23b. DATE THEREOF<br><b>1/26/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>ARLINGTON NATIONAL</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>ARLINGTON, VIRGINIA</b> |
| 24. FUNERAL DIRECTOR<br><b>MESSICK FUNERAL HOME</b>   |   | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 25 1967</b>  |   |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   |   |



00457

CERTIFICATE OF DEATH

00460

|  |  |   |  |
|--|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b><br>MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b><br>b. COUNTY<br><b>BALTIMORE</b>   |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>   |  | c. LENGTH OF STAY IN 1b<br><b>43 DAYS</b>   |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  | d. STREET ADDRESS<br><b>1827 REDWOOD AVENUE</b>   |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>HARRY LEE VAN HORN</b>   |  | 4 DATE OF DEATH<br>Month Day Year<br><b>JANUARY 1 1967</b>  |  |
| 5 SEX<br><b>MALE</b>   | 6 COLOR OR RACE<br><b>WHITE</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>OCTOBER 17, 1894</b> |
| 9 AGE (n years last birthday)<br><b>72 yrs</b>   |  | 10 IF UNDER 1 YEAR<br>Months Days Hours Min.<br><b>19 67</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PAYMASTER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>FACTORY</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>PITTSBURGH, PENNA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13 FATHER'S NAME<br><b>CORNELIUS VAN HORN</b>  |  | 14 MOTHER'S MAIDEN NAME<br><b>CLARA HOBURG</b>  |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WWI</b>   |  | 16 SOCIAL SECURITY NO<br><b>214 01 36 27</b>  |  |
| 17 INFORMANT<br><b>VA HOSPITAL</b>   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><b>ESOPHAGEAL VARICES AND ULCERATION WITH HEMORRHAGE</b><br>DUE TO (b)<br><b>CIRRHOSIS OF LIVER</b><br>DUE TO (c)<br><b>INTERVAL BETWEEN ONSET AND DEATH<br/>RECENT YEARS</b> |  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>BRONCHOPNEUMONIA, BILATERAL AND GENERALIZED ARTERIOSCLEROSIS</b>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m.<br><b>19</b>   | 20d INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)       |
| 21. I certify that (X) (this hospital) attended the deceased from <b>NOV 19</b> , 19 <b>66</b> to <b>JAN 1</b> , 19 <b>67</b> , that (X) (we) lost saw the deceased alive on <b>JAN 1</b> , 19 <b>67</b> , and that death occurred at <b>650A M.</b> from causes on and the date stated above. |  |   |  |
| 22a. SIGNATURE<br><i>J. D. Talbert</i>   |  | 22b. DATE SIGNED<br><b>1/3/67</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JOHN D. TALBERT, M. D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>  |  |
| 23a. BURIAL OR CREMATION<br><b>CREMATION</b>   | 23b. DATE THEREOF<br><b>JAN. 6, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>GREENMOUNT CEMETERY</b>  |  |
| 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>  |  | 23e. REC'D BY REGISTRAR<br><b>BURNS' FUNERAL HOME</b>   |  |
| 23f. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  | 23g. DATE<br><b>JAN 9 1967</b>  |  |
| 23h. ADDRESS<br><b>610 YORK ROAD, BALTIMORE, MD.</b>   |  | 23i. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only day is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film 3384 1/17/67 mh

00458

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00461

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a COUNTY <b>BALTIMORE</b> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)<br>a STATE <b>MARYLAND</b> b COUNTY <b>BALTIMORE</b>                 |  |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>CATONSVILLE</b>   |  | c LENGTH OF STAY IN b<br><b>244</b>   |  |
| d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSP.</b>  |  | e STREET ADDRESS <b>222 W. Lafayette St.</b>  |  |
| 3 NAME OF DECEASED<br>(Type or print) <b>THOMAS W. VICKERS</b>  |  | 4 DATE OF DEATH<br>Month <b>JAN.</b> Day <b>10</b> Year <b>1967</b>   |  |
| 5. SEX<br><b>M</b>  | 6 COLOR OR RACE<br><b>W</b>  | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>12/2/1923</b>  |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 11 BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD</b>  |  |
| 10b KIND OF BUSINESS OR INDUSTRY  |  | 12 CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13 FATHER'S NAME<br><b>GEORGE R. VICKERS III</b>  |  | 14 MOTHER'S MAIDEN NAME<br><b>HELEN M. THOMAS</b>   |  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>   |  | 16 SOC. SEC. NO.<br><b>NONE</b>   |  |
| 17 INFORMANT<br><b>CHART</b>  |  | Address   |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>SCHIZOPHRENIA</b><br>DUE TO <b>2) CATATONIA</b><br>(b) <b>3) EPILEPSY</b><br>DUE TO <b>4) ASPIRATION OF FOOD due to 1, 2, 3</b><br>(c) <b>1, 2, 3</b>   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <b>7:00 PM.</b> |  |   |  |
| ACTUAL SIGNATURE <b>E. Kasariotis</b> M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type) <b>E. KASARIOTIS, M.D.</b>   |  | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>   |  |
|   |  | DEPUTY MEDICAL EXAMINER <input type="checkbox"/>  |  |
|   |  | Address (Street, city, town, or county)   |  |
| 22a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 22b DATE THEREOF<br><b>Jan. 13, 1967</b>   | 22c NAME OF CEMETERY OR CREMATORY<br><b>Green Mount Cemetery</b>  | 22d LOCATION (City or Town) (County) (State)<br><b>Baltimore, Maryland</b>                       |
| 24. FUNERAL DIRECTOR<br><b>ST. ART &amp; MOWEN CO., 108 N. North Av., Balto.</b>  |  | 25a REC'D BY REGISTRAR<br><b>DATE JAN 12 1967</b>   | 25b REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

00459

00462

|   |                                  |   |                                      |   |   |   |   |
|---|----------------------------------|---|--------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND   |                                  |   |                                      | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u> |   |   |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>BALTIMORE COUNTY</u>   |                                  | c. LENGTH OF STAY IN lb<br><u>90</u>  |                                      | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE COUNTY, MARYLAND</u>                          |   |   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8141 Loch Raven Bro. Baltimore</u>  |                                  |   |                                      | d. STREET ADDRESS <u>8141 LOCHRIVEN BRO.</u>  |   | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 3. NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>THERESA MARY VOELKIER</u>  |                                  |   |                                      | 4. DATE OF DEATH<br>Month Day Year<br><u>1 21 19 67</u>   |   |   |   |
| 5. SEX<br><u>F</u>  | 6. COLOR OR RACE<br><u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/5/1877</u> | 9. AGE (In years last birthday)<br><u>90</u> yrs  | IF UNDER 1 YEAR<br>Months Days Hours Min. |   | IF UNDER 24 HRS<br>Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>HOUSE WIFE</u>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (County & State, or foreign country)<br><u>BALTIMORE CITY</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>US</u>   |   |
| 13. FATHER'S NAME<br><u>ADAM MUELLER</u>  |                                  |   |                                      | 14. MOTHER'S MAIDEN NAME<br><u>MARY HEIL</u>  |   |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |                                  | 16. SOCIAL SECURITY NO<br><u>220-54-74</u>  |                                      | 17. INFORMANT <u>MRS MARY DAUGHTER BROWN</u> Address <u>BALTIMORE 4</u><br><u>8141 LOCHRIVEN BRO</u>  |   |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>ACUTE CVA</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u><br>DUE TO<br>(c) <u>ARTERIOSCLEROSIS GENERAL</u> |                                  |   |                                      |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 WEEKS</u><br><u>20 YEARS</u><br><u>20 YEARS</u>          |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH; BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><u>no</u>   |                                  |   |                                      |   |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                      |   |   |   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour am p.m. <u>19</u>  |                                  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work   |                                      | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |   | 20f. (City or town) (County) (State)  |   |
| 21. I certify that (1) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>60</u> , to <u>1/21</u> , 19 <u>67</u> , that (1) (we) last saw the deceased alive on <u>1/20</u> , 19 <u>67</u> , and that death occurred at <u>12:50</u> P.M., from causes and on the date stated above.   |                                  |   |                                      |   |   |   |   |
| 22a. SIGNATURE<br><u>A Margaret Zaneckaus</u>   |                                  |   |                                      | M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>          |   | 22b. DATE SIGNED<br><u>1/21/1967</u>  |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>ATTENDING PHYSICIAN, INTERNAL MEDICINE, SELF-EMPLOYED</u>  |                                  |   |                                      | 22d. ADDRESS<br><u>7028 BELLONA AVE BALTIMORE 12, MD</u>  |   |   |   |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                                  | 23b. DATE THEREOF<br><u>1/24/67</u>   |                                      | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Holy Redeemer Cem</u>  |   | 23d. LOCATION (City or Town) (County) (State)<br><u>Baltimore, Md.</u>                            |   |
| 24. FUNERAL DIRECTOR<br>ADDRESS<br><u>Dippel Bro's. Inc. 7110 Belair Rd.</u>  |                                  |   |                                      | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 24 1967</u>  |   | 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |





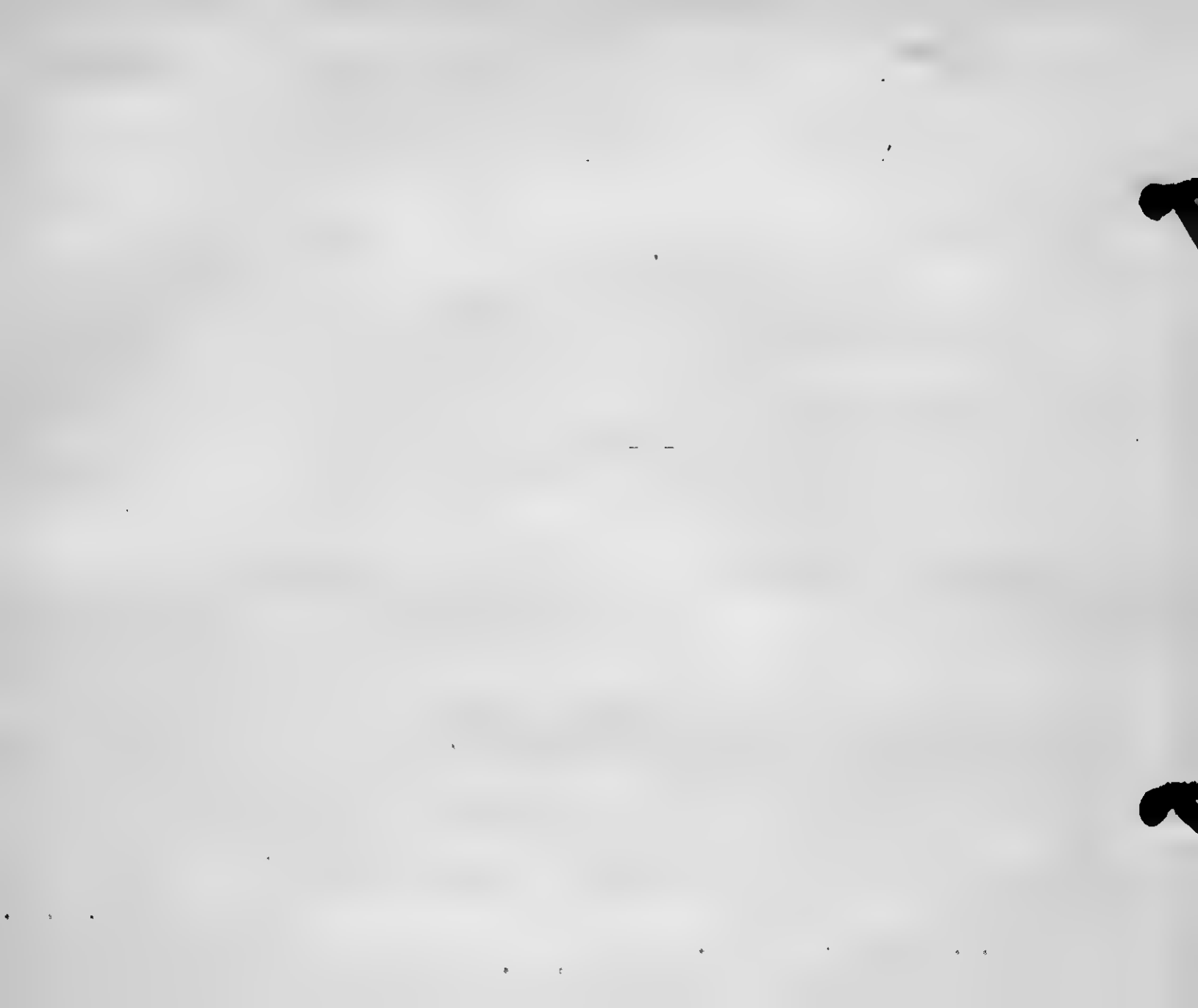
00460

CERTIFICATE OF DEATH

00463

|  |  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lowson</u><br>c. LENGTH OF STAY IN <u>9 months</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>   |  |  |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission)<br>a. STATE <u>Md</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>4301 Roland Ave.,</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |  |  |  |  |
| <b>3. NAME OF DECEASED</b> (Type or print)<br><u>Mabel C. Wachter</u>  |  | <b>4. DATE OF DEATH</b><br><u>1 14 19 67</u> |  | <b>5. SEX</b><br><u>F</u>   |  | <b>6. COLOR OR RACE</b><br><u>W</u>  |  | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b><br><u>10/25/81</u>   |  | <b>9. AGE</b> (In years last birthday) <u>85</u> yrs.<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u><br><b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Columbus, Ohio</u><br><b>12. CITIZEN OF WHAT COUNTRY</b> <u>USA</u> |  |
| <b>13. FATHER'S NAME</b><br><u>Howard Carlton</u>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Mary Marshall</u>   |  |  |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>216-46-1644</u><br><b>17. INFORMANT</b> <u>Hospice records</u> Address _____ |  |  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u><br>(b) _____<br>(c) _____<br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>DUE TO<br>(b) _____<br>(c) _____ |  |  |  |   |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH <u>years</u>  |  |
| <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>   |  |  |  |   |  |  |  |  |  |  |  |
| <b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____   |  |  |  |  |  |  |  |
| <b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. _____ p.m. <u>19</u>  |  |  |  | <b>20d. INJURY OCCURRED</b><br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  | <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____  |  | <b>20f. (City or town)</b> _____ (County) _____ (State) _____  |  |  |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>3/28/66</u> <b>19</b> <u>to Jan 14</u> <b>19</b> <u>67</u> <b>that (I) (we) last saw the deceased alive on</b> <u>Jan. 13</u> <b>19</b> <u>67</u> <b>and that death occurred at</b> <u>5:18 P.</u> <b>from the causes and on the date stated above</b>                                 |  |  |  |   |  |  |  |  |  |  |  |
| <b>22a. SIGNATURE</b><br><u>Frank Keuhn, M.D.</u>  |  |  |  |   |  | <b>ATTENDING PHYS.</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input checked="" type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> |  | <b>22b. DATE SIGNED</b><br><u>1/14/67</u>  |  |  |  |
| <b>22c. PHYSICIAN'S NAME</b> (Type)<br><u>Frank Keuhn, M.D.</u>  |  |  |  |   |  | <b>22d. ADDRESS</b><br><u>Medical Arts. Bldg, Balto., Md</u>   |  |  |  |  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>  |  |  |  | <b>23b. DATE THEREOF</b><br><u>1/17/1967</u>  |  | <b>23c. NAME OF CEMETERY OR CREMATORY</b><br><u>Druid Ridge</u>  |  | <b>23d. LOCATION</b> (City, town or county) <u>Pikesville, Balto. Co. Md.</u> (State) _____  |  |  |  |
| <b>24. FUNERAL DIRECTOR'S SIGNATURE</b><br><u>H.W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</u>   |  |  |  |   |  | <b>25a. REC'D BY REGISTRAR</b> <u>JAN 17 1967</u> <b>25b. REGISTRAR'S SIGNATURE</b><br><u>Charles Judge</u>  |  |  |  |  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00462

# CERTIFICATE OF DEATH

00464

|   |                                 |   |  |   |  |  |  |
|---|---------------------------------|---|--|---|--|--|--|
| 1 PLACE OF DEATH<br>a. COUNTY <b>Maryland, Baltimore</b> MARYLAND   |                                 |   |  | 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> |  |  |  |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>  |                                 |   | c. LENGTH OF STAY IN lb<br><b>1mth2ldys</b>                            |   | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Captiol Heights, Maryland</b> |  |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>  |                                 |   |  | d. STREET ADDRESS<br><b>6118 Central Avenue</b>   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  |
| 3 NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>Alburb B. Waller</b>  |                                 |   |  | 4 DATE OF DEATH<br>Month Day Year<br><b>January 16 1967</b>   |  |  |  |
| 5 SEX<br><b>male</b>  | 6 COLOR OR RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>April 5, 1907</b>                               |   | 9. AGE (In years lost birthday) yrs.<br><b>59</b>  | IF UNDER 1 YEAR<br>Months Days Hours Min.  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumber</b>   |                                 | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>Virginia</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |  |
| 13. FATHER'S NAME<br><b>J. L. Waller</b>  |                                 |   | 14. MOTHER'S MAIDEN NAME<br><b>Mattie ?</b>                            |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>NO</b>  |                                 | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b> Address  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Squamous cell carcinoma of the epiglottis</b><br>DUE TO <b>and pharynx, with metastases</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) |                                 |   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |                                 |   |  |   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |                                 | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  |                                 | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |   | 20f. (City or town) (County) (State)   |  |  |
| 21. I certify that <del>the</del> (this hospital) attended the deceased from <b>Nov. 25, 1966</b> to <b>Jan. 16, 1967</b> , that <del>he</del> (we) last saw the deceased alive on <b>Jan. 16, 1967</b> , and that death occurred at <b>10:10 P.</b> M, from causes and on the date stated above.   |                                 |   |  |   |  |  |  |
| 22a. SIGNATURE<br><i>Stella Wachslar</i>  |                                 | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>                        |  | 22b. DATE SIGNED<br><b>1-17-67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Stella Wachslar, M.D.</b>  |                                 | 22d. ADDRESS<br><b>SPRING GROVE STATE HOSPITAL<br/>Baltimore, Maryland 21228</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                                 | 23b. DATE THEREOF<br><b>1/19/67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>  |  | 23d. LOCATION (City or Town) (County) (State)<br><b>Prince Georges, Maryland</b>                             |  |
| 24. FUNERAL DIRECTOR <b>Wilhelm Funeral Home</b> ADDRESS<br><b>4308 Suitland Road, Suitland Md.</b>   |                                 |   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 20 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>John A. Judge</i>   |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00463

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00465

|  |                               |   |                                    |  |  |   |                               |
|--|-------------------------------|---|------------------------------------|--|--|---|-------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND   |                               |   |                                    | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b> |  |   |                               |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>ARBUTHUS</b>  |                               | c. LENGTH OF STAY IN 1b <b>2 1/2 YRS</b>  |                                    | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ARBUTHUS</b>   |  |   |                               |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to, give street address) <b>1252 STEVENS AVE</b>  |                               |   |                                    | d. STREET ADDRESS <b>1252 STEVENS AVE</b>  |  | e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               |
| 3. NAME OF DECEASED (Type or print) <b>MARGARET VIOLA WALTZ</b>  |                               |   |                                    | 4. DATE OF DEATH <b>JAN 12 1967</b>  |  |   |                               |
| 5. SEX <b>FEMALE</b>   | 6. COLOR OR RACE <b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <b>OCT 6 1891</b> | 9. AGE (In years last birthday) <b>75</b> yrs.   | IF UNDER 1 YEAR<br>Months Days Hours Min |   | IF UNDER 24 HRS.<br>Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY WORKER</b>  |                               | 10b. KIND OF BUSINESS OR INDUSTRY <b>LAUNDRY</b>  |                                    | 11. BIRTHPLACE (State and foreign country) <b>CARROLL COUNTY MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                               |
| 13. FATHER'S NAME <b>ISAAC FRIZZELL</b>  |                               |   |                                    | 14. MOTHER'S MAIDEN NAME <b>EMMA BARNES</b>  |  |   |                               |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>  |                               | 16. SOCIAL SECURITY NO <b>215056523</b>   |                                    | 17. INFORMANT <b>MRS HELEN WOLF</b>  |  | Address <b>536 ALDEN ST BALTIMORE MD</b>  |                               |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4201</b> DUE TO <b>CORONARY OCCLUSION</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>ARTERIOSCLEROTIC HEART DIS.</b> DUE TO <b>HYPERTENSION.</b> (c) <b>HYPERTENSION.</b>   |                               |   |                                    | INTERVA. BETWEEN ONSET AND DEATH   |  |   |                               |
| PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)   |                               |   |                                    |  |  | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>         |                               |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                               | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)  |                                    |  |  |   |                               |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                               | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                    | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |                               |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                               |   |                                    |  |  |   |                               |
| ACTUAL SIGNATURE <b>John N. Snyder</b> M.D.  |                               |   |                                    | CHIEF MEDICAL EXAMINER <input type="checkbox"/>  |  |   |                               |
| EXAMINER'S NAME (Type) <b>JOHN N. SNYDER M.D.</b>  |                               |   |                                    | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>  |  |   |                               |
|  |                               |   |                                    | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |   |                               |
|  |                               |   |                                    | Address (Street, city, town, or county) <b>6348 FREDERICK RD.</b>  |  |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                               | 23b. DATE THEREOF <b>1/16/1967</b>  |                                    | 23c. NAME OF CEMETERY OR CREMATORY <b>Taylorville Cemetery</b>   |  | 23d. LOCATION (City or Town) (County) (State) <b>Carroll Co., Md.</b>                       |                               |
| 24. FUNERAL DIRECTOR <b>C. M. Waltz</b> Box 241 Sykesville, Md.  |                               |   |                                    | 25a. REC'D BY REGISTRAR <b>JAN 16 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>   |                               |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00464

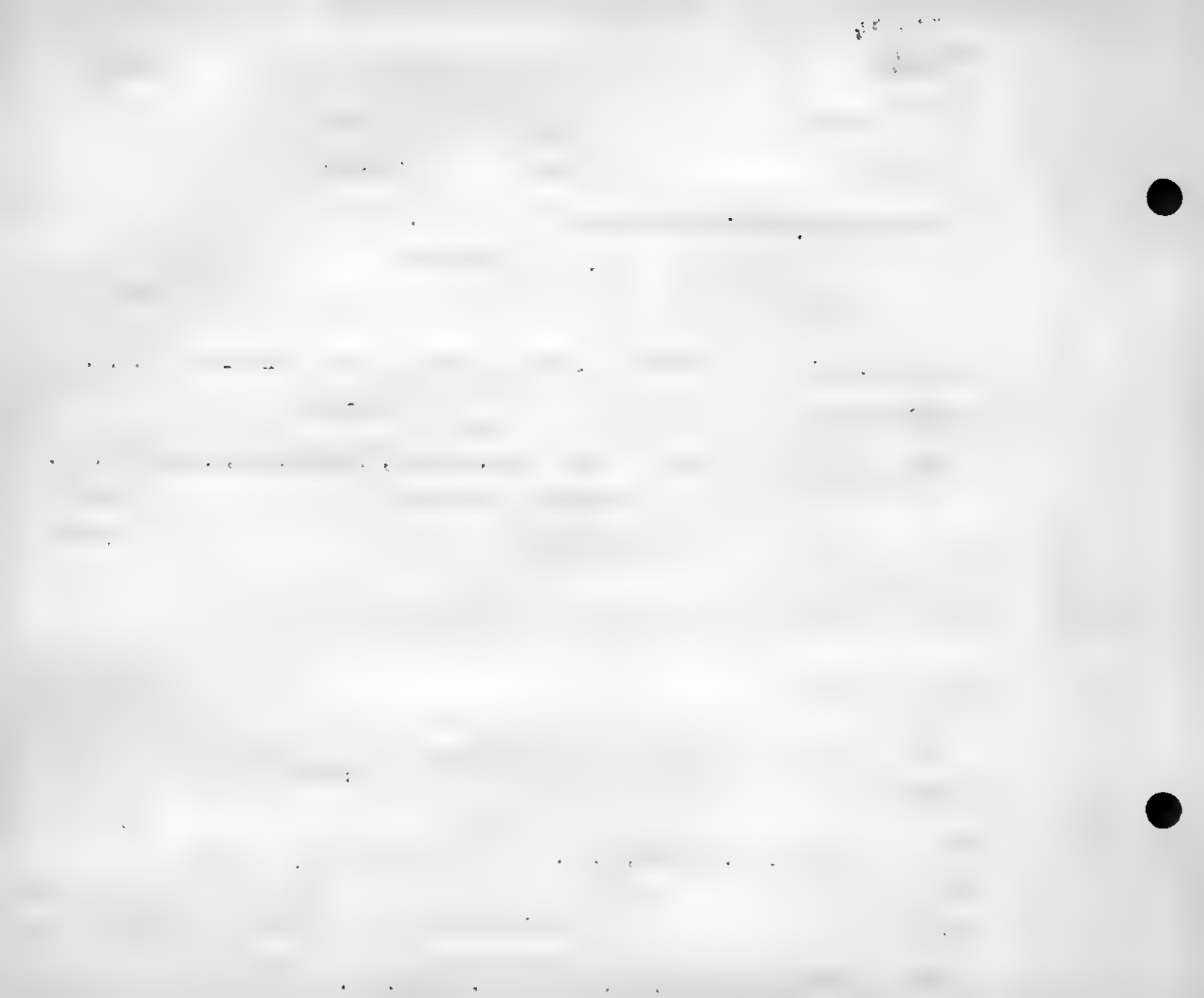
## CERTIFICATE OF DEATH

00466

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>  |  | c. LENGTH OF STAY IN 1b<br><b>2 1/2 HOURS</b>  |  | 2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b> |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |  |  | d. STREET ADDRESS<br><b>1925 N. DIVISION STREET</b>  |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CHARLES</b> Middle <b>F.</b> Last <b>WARFIELD</b>  |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>9</b> Year <b>1967</b>   |  | 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>NEGRO</b>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH<br><b>APRIL 13, 1902</b>  |  | 9. AGE (In years last birthday) <b>64</b>  |  | 10. IF UNDER 1 YEAR<br>Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>                    |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)<br><b>STREET CLEANER</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>BALTIMORE CITY</b>   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>HARFORD COUNTY, MARYLAND</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>JAMES WARFIELD</b>   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>GAROW SHEPHERD</b>  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |  | 16. SOCIAL SECURITY NO<br><b>705 10 31 27</b>  |  | 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>INTRAPERITONEAL HEMORRHAGE</b><br>DUE TO <b>LIVER CIRRHOSIS</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b)<br>(c)<br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) |  |  |  |  |  | INTERVAL BETWEEN DEATH<br><b>HOURS</b><br><b>YEARS</b>   |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  |  |  |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b> p.m. <b>19</b>   |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>                            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)  |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1/9/67</b> to <b>1/9/67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1/9/67</b> 19__, and that death occurred at <b>12:20 PM</b> 19__, from causes and on the date stated above.   |  |  |  |  |  |  |  |
| 22a. SIGNATURE<br><i>Jorge A. Fabara</i>   |  | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/9/67</b>  |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>JORGE A. FABARA, M. D.</b>  |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>1-13-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL CEM.</b>   |  | 23d. LOCATION (City or town) (County) (State)<br><b>BALTIMORE, MARYLAND</b>                          |  |
| 24. FUNERAL DIRECTOR<br><i>Charles J. Bullock</i>  |  | ADDRESS<br><b>Bullock Funeral Home</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 16 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J. Bullock</i>  |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

00465

CERTIFICATE OF DEATH

00467

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b><br>c. LENGTH OF STAY IN 1b <b>133 DAYS</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>MARYLAND</b><br>b. COUNTY <b>BALTIMORE</b><br>c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>BALTIMORE</b><br>d. STREET ADDRESS <b>2810 ALLENDALE ROAD</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>CARL</b> Middle <b>--</b> Last <b>WARNER</b>   |  |  |  | 4. DATE OF DEATH<br>Month <b>JANUARY</b> Day <b>11</b> Year <b>1967</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>  |  | 6. COLOR OR RACE<br><b>NEGRO</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br><b>JANUARY 8, 1908</b>   |  |
| 9. AGE (In years last birthday) <b>59 yrs</b>  |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CRANE OPERATOR</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>BALTIMORE, MD.</b>                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |  |  | 13. FATHER'S NAME<br><b>HOWARD WARNER</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>FLORENCE JENNINGS</b>   |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>219 01 68 89</b>   |  |  |  | 17. INFORMANT<br><b>CLIN. RECORDS, VA HOSPITAL FT HOWARD, MD.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>ABSCCESS OF LEFT UPPER LOBE</b><br>DUE TO (b)<br>0021 (c) |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b><br><b>UNKNOWN</b>                            |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)<br><b>PULMONARY TUBERCULOSIS WITH BILATERAL ADHESIONS, CLINICAL</b>  |  |  |  |   |  | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)                         |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>   |  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work            |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)   |  | 20f. (City or town) (County) (State)   |  |
| 21. I certify that <del>he</del> (this hospital) attended the deceased from <b>8/31/66</b> , 19__ to <b>1/11/67</b> , 19__, that <del>he</del> (we) last saw the deceased alive on <b>1/11/67</b> , 19__, and that death occurred at <b>12:20AM</b> on <b>1/11/67</b> from causes and on the date stated above             |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><i>John D. Talbert</i><br>PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>  |  |  |  | 22b. DATE SIGNED<br><b>1/12/67</b>  |  | 22c. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>    |  |
| 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>1-16-67</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>                         |  |
| 24. FUNERAL DIRECTOR<br><i>Charles R. Law</i> <b>LAW</b>   |  |  |  | 25a. REC'D BY REGISTRAR<br><b>JAN 17 1967</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles Judge</i>   |  |
| 26. FUNERAL HOME<br><b>802 MADISON AVE. BALTIMORE, MD.</b>   |  |  |  |   |  |  |  |



000466

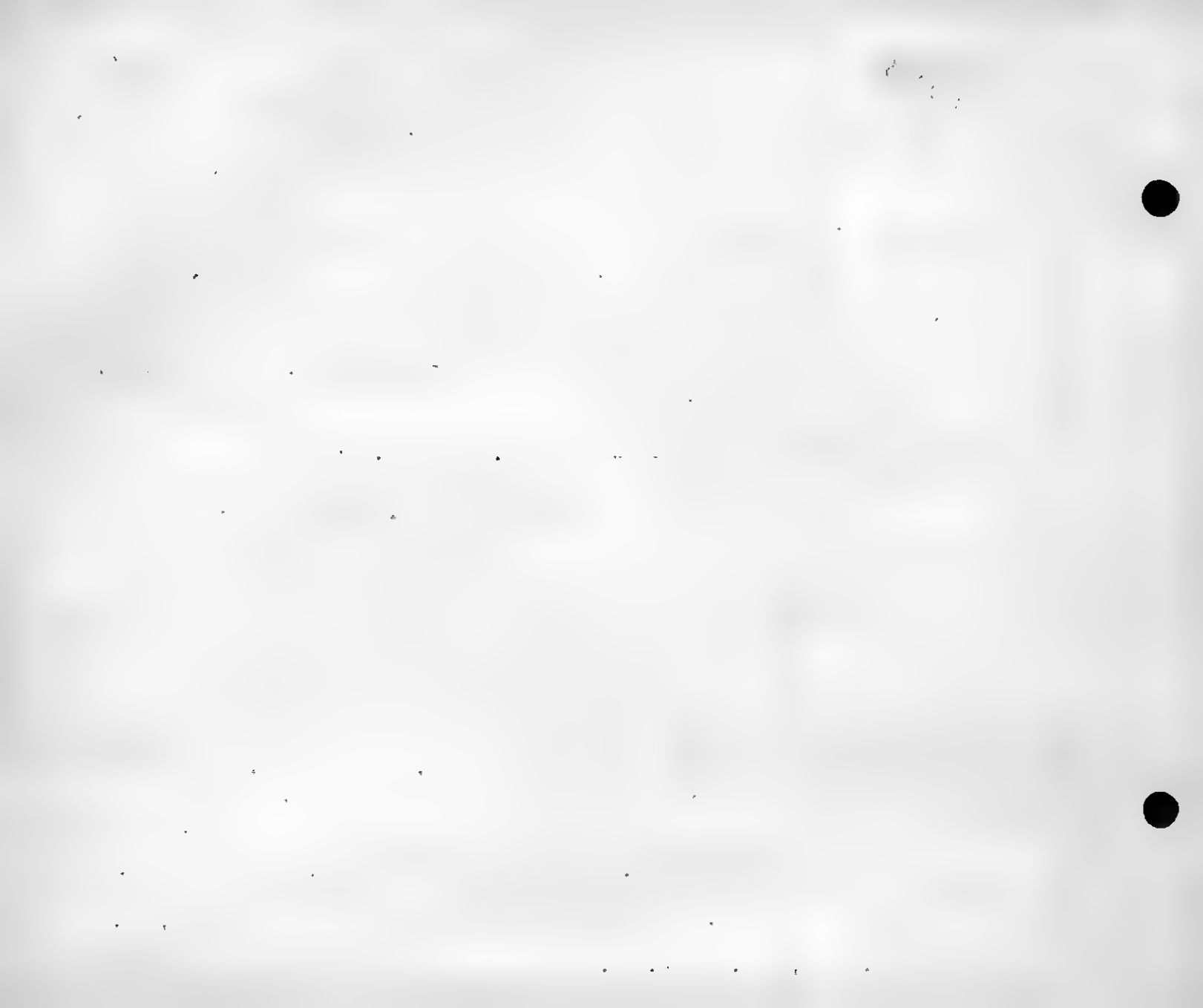
## CERTIFICATE OF DEATH

000468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refer to the carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and to any event, within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (Rural)</b><br>c. LENGTH OF STAY IN <b>1b</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>                   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, 21234</b><br>d. STREET ADDRESS <b>2605 Joppa Terrace</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>FIELDING</b> Middle <b>L.</b> Last <b>WATKINS</b>   |   | 4. DATE OF DEATH<br>Month <b>Jan.</b> Day <b>25</b> Year <b>19 67</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>9/26/96</b><br>9. AGE (In years lost birthday) <b>70</b> yrs                                       |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>   | 11. BIRTHPLACE (County & State or foreign country) <b>Baltimore, Md.</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> |
| 13. FATHER'S NAME <b>Samuel Watkins</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Anna Caskey</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>212-10-1961</b>  |  |
| 17. INFORMANT <b>Mrs. Louise H. Watkins</b>   |   | Address <b>(Same)</b>   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Carcinoma of lung with multiple metastases.</b><br>DUE TO (b) _____<br>DUE TO (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |   |   | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                         |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. _____ p.m. <b>19</b>  | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>12/Dec.</b> , 19 <b>66</b> , to <b>Jan. 25</b> , 19 <b>67</b> , that <b>(A)</b> (we) last saw the deceased alive on <b>Jan. 25</b> , 19 <b>67</b> , and that death occurred at <b>6:05 PM</b> , from causes on and on the date stated above.    |   |   |  |
| 22a. SIGNATURE <b>M.S. Cockburn, M.D.</b>   |   | 22b. DATE SIGNED <b>January 26, 1967</b>  |  |
| 22c. PHYSICIAN'S NAME (Type) <b>M.S. Cockburn, M.D.</b>   |   | 22d. ADDRESS <b>7620 York Rd., Baltimore, Md. 21204</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>   | 23b. DATE THEREOF <b>1/30/67.</b>   | 23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>  |
| 24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 21214</b>  |   | 25a. REC'D BY REGISTRAR <b>JAN 26 1967</b>  | 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>   |



FOR STATE  
HEALTH DEPT.

00461

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00469

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1, 2, 3, and 4. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|  |   |   |  |  |   |
|--|---|---|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <b>BALTIMORE</b> MARYLAND  |   |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> |  |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk</b>   |   | c. LENGTH OF STAY IN 1b   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Dundalk 13.</b> |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>7817 W. Collingham Road Apt. D</b>  |   |   | d. STREET ADDRESS<br><b>7817 W. Collingham Road, Apt. D</b>  |  |   |
| 3 NAME OF DECEASED (Type or print)<br><b>JOHN ROBERT WEAVER</b>  |   |   | 4 DATE OF DEATH<br>Month <b>January</b> Day <b>16</b> Year <b>1967</b>   |  |   |
| 5 SEX<br><b>Male</b>   | 6 COLOR OR RACE<br><b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><b>3-20-1912</b>  | 9 AGE (In years last birthday)<br><b>54 yrs</b>  | 10 UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/> |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Insurance Agent</b>   |   | 10b KIND OF BUSINESS OR INDUSTRY<br><b>Insurance</b>  |  | 11 BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 12 CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |   | 13 FATHER'S NAME<br><b>John R. Weaver</b>  |  |   |
| 14 MOTHER'S MAIDEN NAME<br><b>Marie M. Meckes</b>  |   |   | 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>no</b>                        |  |   |
| 16 SOCIAL SECURITY NO.<br><b>212074770</b>   |   |   | 17 INFORMANT<br><b>G. J. Weaver 1915 Northbourne Rd.</b>   |  |   |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b><br><b>4200</b> DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)<br>(c)<br>DUE TO  |   |   |  |  | INTERVAL BETWEEN ONSET AND DEATH  |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)   |   |   |  |  |   |
| 20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |   | 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |  |  |   |
| 20c TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f (City or town)   | (County)   | (State)   |
| 21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> |   |   |  |  |   |
| ACTUAL SIGNATURE<br><b>Charles S. Springate</b>  |   |   | 22. DATE SIGNED<br><b>January 16, 1967</b>   |  |   |
| EXAMINER'S NAME (Type)<br><b>Charles S. Springate, M.D.</b>  |   |   | 23a BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |   |
| 23b DATE THEREOF<br><b>1-19-67</b>   |   |   | 23c NAME OF CEMETERY OR CREMATORY<br><b>Woodlawn Cemetery</b>  |  |   |
| 23d LOCATION (City or Town)<br><b>Baltimore, Md.</b>   |   |   | 23e RECORD BY REGISTRAR<br><b>JAN 23 1967</b>  |  |   |
| 23f REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |   |   | 23g RECD BY REGISTRAR<br><b>JAN 23 1967</b>  |  |   |
| 24 FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc Baltimore, Md.</b>   |   |   |  |  |   |



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 1  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 2

VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

00467

00470

|   |  |   |  |
|---|--|---|--|
| <b>1. PLACE OF DEATH</b><br>a. COUNTY <u>BALTIMORE</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u><br>c. LENGTH OF STAY IN 1b <u>MARYLAND</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOUSE OF THE PINES, CATONSVILLE</u>   |  | <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before adm-ss on)<br>a. STATE <u>MARYLAND</u><br>b. COUNTY <u>BALTO. CITY</u><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u><br>d. STREET ADDRESS <u>1920 WILMINGTON AVE</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>3. NAME OF DECEASED</b> (Type or print) <u>AUGUST George WEIBE</u><br>First Middle Last<br>4. DATE OF DEATH <u>1</u> <u>16</u> <u>1967</u><br>Month Day Year   |  | <b>5. SEX</b> <u>male</u><br><b>6. COLOR OR RACE</b> <u>W</u><br><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/><br><b>8. DATE OF BIRTH</b> <u>10-14-1909</u><br><b>9. AGE</b> (In years last birthday) <u>57</u> yrs.<br><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Color Matcher</u><br><b>11. BIRTHPLACE</b> (County & State or foreign country) <u>Baltimore, Maryland</u><br><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>AMERICAN U.S.A.</u> |  |
| <b>13. FATHER'S NAME</b> <u>Otto Weibe</u><br><b>14. MOTHER'S MAIDEN NAME</b> <u>Bessie M. Carson</u>   |  | <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u><br><b>16. SOCIAL SECURITY NO.</b> <u>220-03-4253</u><br><b>17. INFORMANT</b> <u>Mrs. Margaret R. Weibe, 1920 Wilmington Ave.</u><br>Address  |  |
| <b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <u>DIABETES MELLITUS</u><br>DUE TO <u>BRAIN ORGANELLE MONIA</u><br>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1</u> <u>mo</u><br><u>years</u><br><u>days</u>   |  |
| <b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/><br><b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)<br><b>20c. TIME OF INJURY</b> Month, Day, Year<br>Hour a.m. p.m. <u>19</u><br><b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/><br><b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)<br><b>20f. (City or town)</b> (County) (State) |  | <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| <b>21. I certify that (I) (this hospital) attended the deceased from <u>12-19-1966</u> to <u>1-16-1967</u>, that (I) (we) last saw the deceased alive on <u>1-16-1967</u>, and that death occurred at <u>2:57 PM</u>, from the causes and on the date stated above.</b>   |  |   |  |
| <b>22a. SIGNATURE</b> <u>Manuel J. Rodriguez</u><br><b>22c. PHYSICIAN'S NAME (Type)</b> <u>MANUEL J. RODRIGUEZ MD</u><br><b>22d. ADDRESS</b> <u>455 CHARFONTE DR BALTO 28 MD</u>  |  | <b>22b. DATE SIGNED</b> <u>1-16-67</u><br><b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>  |  |
| <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u><br><b>23b. DATE THEREOF</b> <u>1-19-1967</u><br><b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Loudon Park Cemetery</u><br><b>23d. LOCATION (City, town or county)</b> <u>Baltimore, Maryland</u> (State)  |  | <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u><br><b>25a. REC'D BY REGISTRAR</b> <u>JAN 18 1967</u><br><b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>  |  |





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT

00468

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00471

|   |   |  |   |
|---|---|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Balto.</u> MARYLAND  |   | 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE <u>Md</u> b. COUNTY <u>Balto</u>                           |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Phoenix</u>  |   | c. LENGTH OF STAY IN 1b<br><u>Life</u>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  |   | d. STREET ADDRESS<br><u>Blenheim Rd.</u>   |   |
| 3 NAME OF DECEASED<br>(Type or print) First Middle Last<br><u>MELVIN E. Whims</u>   |   | 4 DATE OF DEATH<br>Month Day Year<br><u>1/6/67</u> 19 <u>67</u>  |   |
| 5 SEX<br><u>M</u>   | 6 CO. OR RACE<br><u>NEGRO</u>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>12/15/05</u>  |
| 9 AGE (In years last birthday)<br><u>61</u> yrs   |   | 10 UNDER 1 YEAR<br>Months Days Hours Min<br><u>19</u>  |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Labourer</u>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><u>Farm</u>   |   |
| 11 BIRTHPLACE (State or foreign country)<br><u>Md.</u>  |   | 12 CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |   |
| 13 FATHER'S NAME<br><u>Geo. Whims</u>   |   | 14 MOTHER'S MAIDEN NAME<br><u>Matilda ?</u>  |   |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><u>no</u>  |   | 16 SOCIAL SECURITY NO<br><u>20000</u>  |   |
| 17 INFORMANT<br><u>Annie M. Whims</u>   |   | Address<br><u>Phoenix, Md.</u>   |   |
| 18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)<br><u>350X</u><br>DUE TO<br>(b) <u>Coronary Occlusion</u><br>(c) <u>Arteriosclerotic Cardio-Renal</u><br>Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last<br><u>Vascular Disease</u><br><u>Parkinsonism</u>   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>Sudden</u><br><u>10 yrs +</u><br><u>10 yrs +</u>  |   |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  |   | 19 WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. pm 19 <u>67</u>   | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)  |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |  |   |
| ACTUAL SIGNATURE<br><u>Charles F. O'Donnell</u>   |   | 22. DATE SIGNED<br><u>1/7/67</u>   |   |
| EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>  |   | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>  | 23b. DATE THEREOF<br><u>1/10/67</u>   | 23c. NAME OF CEMETERY OR CREMATORY<br><u>Smt. Iron</u>   | 23d. LOCATION (City or town) (County) (State)<br><u>Songreen, Balto Co. Md.</u> |
| 24 FUNERAL DIRECTOR<br><u>W. L. Whitman</u>   |   | 25a. REC'D BY REGISTRAR<br>DATE <u>JAN 10 1967</u>   |   |
| 25b. REGISTRAR'S SIGNATURE<br><u>Charles Judge</u>  |   |  |   |



00469

CERTIFICATE OF DEATH

00472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

|  |  |  |   |
|--|--|--|---|
| 1 PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u> MARYLAND  |  | 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)<br>a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>                |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><u>Owings Mills</u>  |  | c. LENGTH OF STAY IN 1b<br><u>43 yrs.</u>  |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><u>Owings Mills, Md.</u>   |  | d. STREET ADDRESS<br><u>Chattolane Hill</u>  |   |
| 3 NAME OF DECEASED (Type or print) <u>Edward Dostick Whitman</u>   |  | 4 DATE OF DEATH<br>Month <u>January</u> Day <u>26</u> Year <u>1967</u>   |   |
| 5 SEX<br><u>Male</u>   | 6. COLOR OR RACE<br><u>White</u>   | 7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH<br><u>Nov. 6, 1888</u>                                    |
| 9 AGE (In years last birthday) <u>78</u> yrs   |  | 10 IF UNDER 1 YEAR<br>Months <u>0</u> Days <u>0</u>  |   |
| 11 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>retired</u>  |  | 12. KIND OF BUSINESS OR INDUSTRY<br><u>Banking</u>   |   |
| 13. FATHER'S NAME<br><u>Charles S. Whitman</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Nancy deSaurre Dostick</u>  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)<br><u>yes. W.W. I</u>   |  | 16. SOCIAL SECURITY NO.<br><u>unknown</u>  |   |
| 17. INFORMANT<br><u>Mr. Edward D. Whitman, Owings Mills, Md.</u>   |  | Address  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>myocardial infarction acute</u><br>440.1 DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u><br>DUE TO (c) |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 years</u>   |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><u>None.</u>   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)   |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <u>19</u> p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   | 20f. (City or town) (County) (State)                                      |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1948, 1948</u> to <u>Jan 26, 1967</u> , that (I) (we) last saw the deceased alive on <u>Jan 25, 1967</u> , and that death occurred at <u>3:15 P.M.</u> from causes and on the date stated above.   |  |  |   |
| 22a. SIGNATURE<br><u>Palmer F. C. Williams</u>   |  | 22b. DATE SIGNED<br><u>Jan 28, '67</u>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><u>Palmer F. C. Williams</u>   |  | 22d. ADDRESS<br><u>Lansdown Rd. Owings Mills, Md.</u>  |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><u>Burial</u>   | 23b. DATE THEREOF<br><u>Jan. 28, 1967</u>  | 23c. NAME OF CEMETERY OR CREMATORY<br><u>St. Thomas Cemetery</u>   | 23d. LOCATION (City or Town) (County) (State)<br><u>Owings Mills, Md.</u> |
| 24. FUNERAL DIRECTOR<br><u>Frank H. Newell, Kiderville</u>   |  | 25a. REC'D BY REGISTRAR<br><u>DATE JAN 31 1967</u>   |   |
|  |  | 25b. REGISTRAR'S SIGNATURE<br><u>W. J. Judge</u>   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00470

Item 2 Film 354 1/10/67 mh

CERTIFICATE OF DEATH

00473

|  |                                  |  |                                    |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND   |                                  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <b>D. C.</b> b. COUNTY <b>Prince George Co.</b><br><b>Maryland</b> |                                    |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Catonsville</b>   |                                  | c. LENGTH OF STAY IN 1b<br><b>2yr. 6mo. 21da.</b>  |                                    |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Washington</b>  |                                  | d. STREET ADDRESS<br><b>6305 Eastern Ave N.E.</b>  |                                    |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>SPRING GROVE STATE HOSPITAL</b>   |                                  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |                                    |
| 3. NAME OF DECEASED (Type or print)<br>First Middle Last<br><b>EDWARD WILLIS</b>   |                                  | 4. DATE OF DEATH<br>Month Day Year<br><b>Jan. 1 19 67</b>  |                                    |
| 5. SEX<br><b>male</b>  | 6. COLOR OR RACE<br><b>negro</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>2-10-86</b> |
| 9. AGE (in years last birthday)<br><b>80 yrs</b>   |                                  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.  |                                    |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired</b>  |                                  | 10b. KIND OF BUSINESS OR INDUSTRY  |                                    |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Massachusetts</b>  |                                  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                                    |
| 13. FATHER'S NAME<br><b>unknown</b>  |                                  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |                                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)  |                                  | 16. SOCIAL SECURITY NO.  |                                    |
| 17. INFORMANT<br><b>Records: SPRING GROVE STATE HOSPITAL</b>   |                                  | Address  |                                    |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>3 days</b><br>DUE TO (c) |                                  |  |                                    |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>NONE, EXCEPT Senility</b>  |                                  |  |                                    |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  |  |                                    |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |                                  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)<br><b>none</b>   |                                    |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>   |                                  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |                                    |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |                                  | 20f. (City or town) (County) (State)   |                                    |
| 21. I certify that <b>he</b> (this hospital) attended the deceased from <b>June 10, 1964</b> , to <b>Jan. 1, 1967</b> , that <b>we</b> (we) lost saw the deceased alive on <b>January 1, 1967</b> , and that death occurred at <b>4:25 AM</b> , from causes and on the date stated above     |                                  |  |                                    |
| 22a. SIGNATURE<br><b>Allen W. Lane</b>   |                                  | 22b. DATE SIGNED<br><b>Jan. 1, 1967</b>  |                                    |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Allen W. Lane</b>   |                                  | 22d. ADDRESS<br><b>Spring Grove State Hospital</b>   |                                    |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>15/67</b>  |                                  | 23b. DATE THEREOF<br><b>1/5/67</b>   |                                    |
| 23c. NAME OF CEMETERY OR CREMATORY<br><b>Int. Chert.</b>   |                                  | 23d. LOCATION (City or town) (County) (State)<br><b>Washington, D.C.</b>   |                                    |
| 24. FUNERAL DIRECTOR<br><b>JOHN T. RYAN JR</b>   |                                  | 25a. REC'D BY REGISTRAR<br><b>3015 1/2 R.T.E. 4th fl.</b>  |                                    |
| 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |                                  | DATE <b>JAN 5 1967</b>   |                                    |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00474

00471

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Essex (21)

c. LENGTH OF STAY IN

2. USUAL RESIDENCE (Where deceased lived, if institution; Res. since before admision on, STATE b. COUNTY

Maryland

Baltimore

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Essex (21)

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Box 272 Holly Neck Rd.

Box 272 Holly Neck Rd.

3. NAME OF DECEASED  
(Type or print)

CHARLES JAMES WOLFE

4. DATE OF DEATH

January 12

19 67

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Sept. 14, 1900

9. AGE (In years last birthday)

66 yrs

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Huckster

10b. KIND OF BUSINESS OR INDUSTRY

Produce

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Wolfe

14. MOTHER'S MAIDEN NAME

Lula Bradyhouse

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

218-03-8781

17. INFORMANT

Margaret Wolfe

Same

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(c)

Coronary occlusion  
A-S-C-V-Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

M B Davis M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

M. B. Davis, M.D. 6800 Mornington Rd. Dundalk, Md.

January 12, 1967

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

1/16/67

22c. NAME OF CEMETERY OR CREMATORY

Parkwood Cemetery

22d. LOCATION (City, town, or country)

Baltimore, Md.

23. FUNERAL DIRECTOR

ADDRESS

Bruzdzinski Funeral Home 1407 Eastern Ave. #21

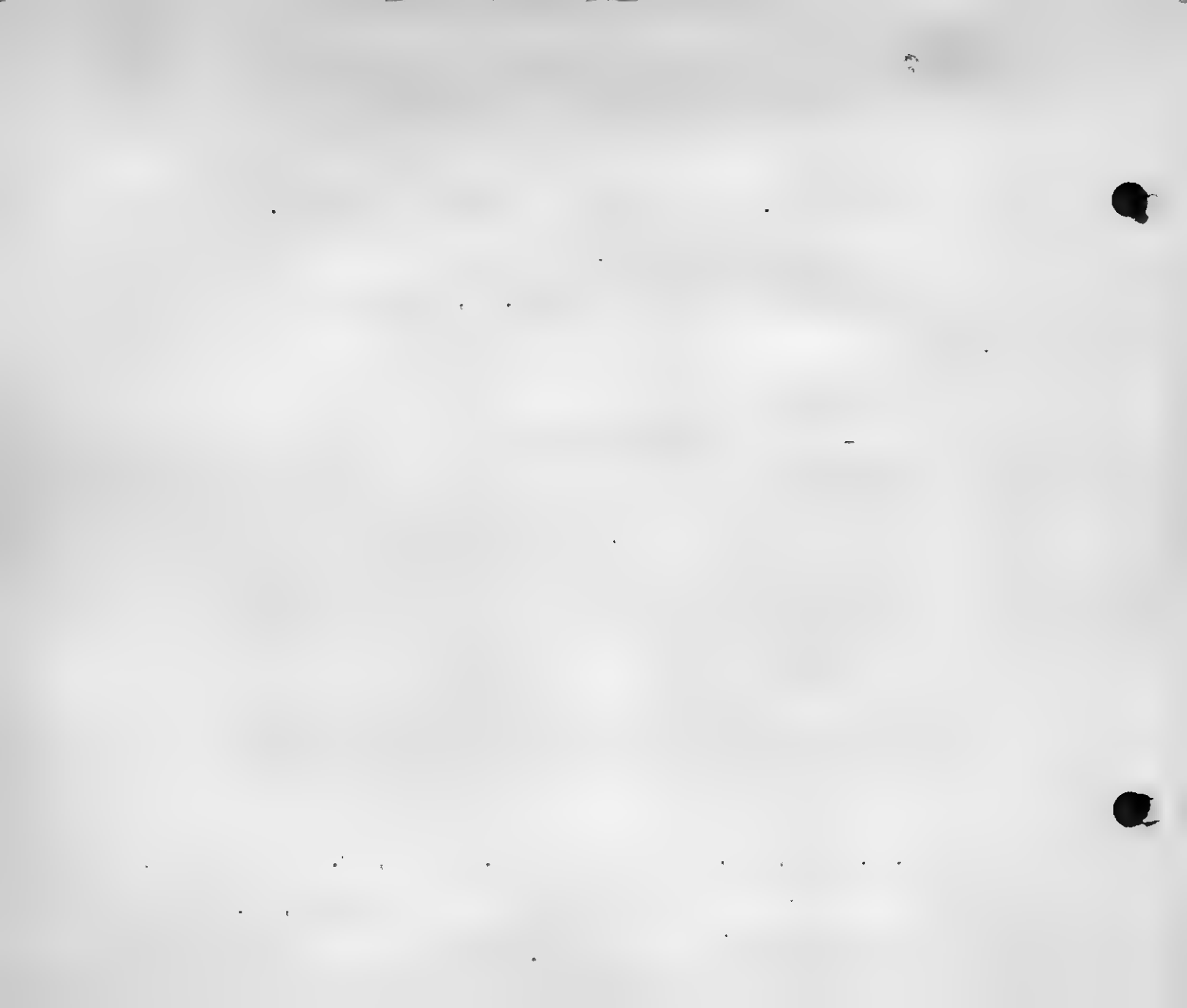
24a. REC'D BY REG. STR.

24b. REGISTRAR'S SIGNATURE

DATE JAN 16 1967

Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit form. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

| MARYLAND STATE DEPARTMENT OF HEALTH   |  |                              |  |  |  |   |  |   |  |  |  |
|---|--|------------------------------|--|--|--|---|--|---|--|--|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  |  |                              |  |  |  |   |  |   |  |  |  |
| CERTIFICATE OF DEATH  |  |                              |  |  |  |   |  |   |  |  |  |
| 00472   |  |                              |  |  |  |   |  |   |  |  |  |
| 00475   |  |                              |  |  |  |   |  |   |  |  |  |
| 1. PLACE OF DEATH<br>a. COUNTY <u>Baltimore</u><br>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u><br>c. LENGTH OF STAY IN TB <u>Life</u><br>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>77 inters Avenue</u> |  |                              |  |  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)<br>a. STATE <u>Md</u><br>b. COUNTY <u>Baltimore</u><br>c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u><br>d. STREET ADDRESS <u>77 inters Avenue</u><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or print) <u>Charles C. Woodland</u>   |  |                              |  |  |  | DATE OF DEATH <u>January-9th.</u> 19 <u>67</u>  |  |   |  |  |  |
| 5. SEX <u>Male</u>  |  | 6. COLOR OR RACE <u>Col.</u> |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH <u>October-9th-1883</u>  |  | 9. AGE (In years last birthday) <u>83</u> yrs |  | IF UNDER 1 YEAR<br>Months Days Hours Min.                                |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>  |  |                              |  | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>  |  | 11. BIRTHPLACE (County & State, or foreign country) <u>Catonsville</u>  |  |   |  | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>                               |  |
| 13. FATHER'S NAME <u>Phillip Woodland</u>   |  |                              |  |  |  | 14. MOTHER'S MAIDEN NAME <u>Sarah Lee</u>   |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>   |  |                              |  |  |  | 16. SOCIAL SECURITY NO. <u>?</u>  |  |   |  |  |  |
| 17. INFORMANT <u>Lucille Cephas</u>   |  |                              |  |  |  | Address <u>Same</u>   |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  |  |                              |  |  |  |   |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u><br>DUE TO (b) <u>Hypertensive C. V. Disease</u><br>DUE TO (c) <u>Chronic Nephritis, Gen. Ail.</u>   |  |                              |  |  |  |   |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)   |  |                              |  |  |  |   |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              |  |  |  |   |  |   |  |  |  |
| 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)  |  |                              |  |  |  |   |  |   |  |  |  |
| 20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. 19  |  |                              |  |  |  |   |  |   |  |  |  |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>  |  |                              |  |  |  |   |  |   |  |  |  |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  |  |                              |  |  |  |   |  |   |  |  |  |
| 20f. City or town (County) (State)  |  |                              |  |  |  |   |  |   |  |  |  |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6.</u> 19 <u>66</u> to <u>1-9</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>1-7</u> 19 <u>67</u> , and that death occurred at <u>12:20 PM</u> , from the causes and on the date stated above.                 |  |                              |  |  |  |   |  |   |  |  |  |
| 22a. SIGNATURE <u>W. L. Weaver</u>  |  |                              |  |  |  | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 1-10-67   |  |   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type) <u>W. L. Weaver, M.D.</u>  |  |                              |  |  |  | 22d. ADDRESS <u>1044 Druid Hill Avenue</u>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>   |  |                              |  | 23b. DATE THEREOF <u>1/12/37</u>   |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Eastern Star Cemetery</u>   |  |   |  | 23d. LOCATION (City, town or county) (State) <u>Catonsville Maryland</u> |  |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Stetson D. Wilson</u>   |  |                              |  |  |  | ADDRESS <u>503 North Calhoun St.</u>  |  |   |  |  |  |
| 25a. REC'D BY REGISTRAR <u>JAN 16 1967</u>  |  |                              |  |  |  | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>   |  |   |  |  |  |



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in paragraph 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00473

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00476

|   |  |   |  |
|---|--|---|--|
| 1 PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Towson</b><br>c. LENGTH OF STAY IN 1b<br><b>10 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>St. Joseph Hospital</b>   |  | 2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission)<br>a. STATE<br><b>Maryland</b><br>b. COUNTY<br><b>121</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Sparks 21152</b><br>d. STREET ADDRESS<br><b>Walters Lane</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3 NAME OF DECEASED<br>(Type or print)<br><b>Lillian</b><br>First Middle Last<br><b>WOODWARD</b>   |  | 4 DATE OF DEATH<br>Month Day Year<br><b>January 4, 19 67</b>  |  |
| 5 SEX<br><b>Female</b>  | 6 CO. OR OR RACE<br><b>White</b>   | 7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8 DATE OF BIRTH<br><b>January 23, 1901</b><br>9 AGE (In years last birthday) <b>65</b> yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>not employed</b>  |  | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Maryland</b>  |  |
| 11. FATHER'S NAME<br><b>Harry Walters</b>   |  | 12. MOTHER'S MAIDEN NAME<br><b>Daisy Bell Shoppert</b>  |  |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>  |  | 14. SOCIAL SECURITY NO.<br><b>212-07-6262D</b>  |  |
| 15. INFORMANT<br><b>Mrs. Vivian Corbin Same as 2-D</b>  |  | Address   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Subdural Cerebral Hemorrhage</b><br>DUE TO <b>Fracture Left Occipital Head</b><br>DUE TO <b>Fracture Left Occipital Head</b><br>DUE TO <b>Fracture Left Occipital Head</b>   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>11 Days</b>  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)   |  | 19. WAS AUTOPSY PERFORMED?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/><br>CAUSE OF DEATH  |  | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II. of item 18)<br><b>Fall down Fight Stairs</b>  |  |
| 20c. TIME OF INJURY Month, Day, Year<br><b>9:00 am 12/5/66</b>  | 20d. INJURY OCCURRED<br>While <input type="checkbox"/> hot While <input type="checkbox"/><br>at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)<br><b>Home</b>   | 20f. (City or town) (County) (State)<br><b>Sparks Maryland</b>                             |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donoghue</b>  |  | 22. DATE SIGNED<br><b>1/4/67</b>  |  |
| EXAMINER'S NAME (Type)<br><b>CHARLES F. O'DONOGHUE, M.D.</b>  |  | Address (Street, city, town, or county)   |  |
| 23a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 23b. DATE THEREOF<br><b>Jan. 7, 1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Dulaney Valley Cemetery</b>  | 23d. LOCATION (City or town) (County) (State)<br><b>Cockeysville, Maryland</b>             |
| 24. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks Towson 1050 York Road Towson, Maryland 21204</b>   |  | 25a. RECD BY REGISTRAR<br><b>JAN 6 1967</b>   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>   |



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00474

## CERTIFICATE OF DEATH

00477

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>c. LENGTH OF STAY IN 1b <b>22 days</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Joseph Hospital</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission)<br>a. STATE <b>Maryland</b><br>b. COUNTY <b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b><br>d. STREET ADDRESS <b>2428 Harwood Road</b><br>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Elmer</b> Middle <b>Howard</b> Last <b>Wright</b>   |   | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>24</b> Year <b>1967</b>   |  |
| 5. SEX <b>Male</b>  | 6. COLOR OR RACE <b>White</b>   | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>10-28-13</b>   |
| 9. AGE (In years last birthday) <b>53</b> yrs   |   | 10. IF UNDER 1 YEAR<br>Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min <b>53</b>  |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY <b>Arts &amp; Crafts Mater. Corp.</b>   |  |
| 11. BIRTHPLACE (County & State, or foreign country) <b>Baltimore, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME <b>George Wright</b>  |   | 14. MOTHER'S MAIDEN NAME <b>Lottie Pratt</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>   |   | 16. SOCIAL SECURITY NO. <b>212-07-5473</b>  |  |
| 17. INFORMANT <b>Mrs. Lottie Wright</b>   |   | Address <b>2428 Harwood Road</b>  |  |
| 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))<br>PART I. DEATH WAS CAUSED BY:<br><b>450.0</b> IMMEDIATE CAUSE (a) <b>Arteriosclerosis of Aorta</b><br>DUE TO (b)<br>DUE TO (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   | INTERVAL BETWEEN ONSET AND DEATH   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  |   |   | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/><br>at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)   | 20f. (City or town) (County) (State)   |
| 21. I certify that (I) (this hospital) attended the deceased from <b>Jan. 2nd</b> , 1967, to <b>Jan. 24th</b> , 1967, that (I) (we) last saw the deceased alive on <b>Jan. 24th</b> , 1967, and that death occurred at <b>12:50 A.M.</b> , from causes and on the date stated above.                        |   |   |  |
| 22a. SIGNATURE<br><b>Pridipongse Vithespongse</b>   |   | 22b. DATE SIGNED<br><b>Jan. 24th 1967</b>   |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>Pridipongse Vithespongse M.D.</b>  |   | 22d. ADDRESS<br><b>7620 York Road Towson 21204, Maryland</b>  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-27-1967</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gardens of Faith Cemetery</b>  | 23d. LOCATION (City or Town) (County) (State)<br><b>Baltimore, Co. Md.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>Lassahn Funeral Home</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 27 1967</b>   |  |
| ADDRESS<br><b>7401 Belair Road</b>  |   | 25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



00475

CERTIFICATE OF DEATH

00478

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>BALTIMORE</b>   |  | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>FORT HOWARD</b>           |  | c. LENGTH OF STAY IN lb<br><b>95 DAYS</b>   |  | 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)<br>a. STATE<br><b>MARYLAND</b>                |  | b. COUNTY   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>BALTIMORE</b> |  |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>VETERANS ADMINISTRATION HOSPITAL</b>  |  |  |  |   |  | d. STREET ADDRESS<br><b>1725 THOMAS AVENUE</b>   |  |   |  | e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>WILLIE GRIM YANCEY</b>  |  | 4. DATE OF DEATH<br>Month<br><b>JANUARY</b><br>Day<br><b>1</b><br>Year<br><b>19 67</b>                           |  | 5. SEX<br><b>MALE</b>   |  | 6. COLOR OR RACE<br><b>NEGRO</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>JUNE 14, 1919</b>   |  |
| 9. AGE (In years last birthday)<br><b>47</b> yrs   |  | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DISHWASHER</b> |  | 10b. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (County & State, or foreign country)<br><b>GRANVILLE, N.C.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |  |  |  |
| 13. FATHER'S NAME<br><b>CHARLIE YANCEY</b>   |  |  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>HATTIE WILKERSON</b>  |  |   |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>YES WW II</b>  |  | 16. SOCIAL SECURITY NO<br><b>240 24 97 73</b>  |  | 17. INFORMANT<br><b>VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND</b>                                |  |  |  |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARCINOMA OF LARYNX WITH METASTASES</b><br>DUE TO (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)<br>DUE TO (c)<br>INTERVAL BETWEEN ONSET AND DEATH             |  |  |  |   |  |  |  |   |  |  |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>STATUS POST LARYNGECTOMY AND RADICAL NECK DISSECTION</b><br>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |   |  |  |  |   |  |  |  |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)   |  |  |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)              |  |  |  |   |  |  |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. <b>19</b><br>p.m.  |  |  |  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> |  | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)   |  | 20f. (City or town) (County) (State)  |  |  |  |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9-28</b> , 19 <b>66</b> to <b>1-1</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JAN 1</b> , 19 <b>67</b> , and that death occurred at <b>4:56 PM</b> , from causes and on the date stated above. |  |  |  |   |  |  |  |   |  |  |  |
| 22a. SIGNATURE<br><i>Milton Ginsberg</i>   |  |  |  |   |  | M.D. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> |  | 22b. DATE SIGNED<br><b>1/3/67</b>   |  |  |  |
| 22c. PHYSICIAN'S NAME (Type)<br><b>MILTON GINSBERG, M. D.</b>  |  |  |  |   |  | 22d. ADDRESS<br><b>VAH FORT HOWARD, MARYLAND</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 23b. DATE THEREOF<br><b>1-6-67</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>BALTIMORE NATIONAL</b>   |  | 23d. LOCATION (City or Town) (County) (State)<br><b>BALTIMORE, MD.</b>   |  |   |  |  |  |
| 24. FUNERAL DIRECTOR<br><i>Turnell B. Oden</i>   |  |  |  | ADDRESS<br><b>ODEN FUNERAL HOME</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>JAN 4 1967</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><i>Charles J...</i>   |  |  |  |
| 1301 Prestman Street, Baltimore, Md.   |  |  |  |   |  |  |  |   |  |  |  |





00476

CERTIFICATE OF DEATH

00476

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

|   |  |   |   |
|---|--|---|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Baltimore</b> MARYLAND  |  | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>                        |   |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>   |  | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Reisterstown</b>   |   |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>9 Delight Road</b>   |  | d. STREET ADDRESS<br><b>9 Delight Road</b>  |   |
| 3. NAME OF DECEASED (Type or print)<br>First <b>Lillian</b> Middle <b>M.</b> Last <b>Yox</b>  |  | 4. DATE OF DEATH<br>Month <b>January</b> Day <b>31</b> Year <b>1967</b>   |   |
| 5. SEX<br><b>Female</b>   | 6. COLOR OR RACE<br><b>White</b>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>June 16, 1889</b>  |
| 9. AGE (In years last birthday) yrs.<br><b>77</b>   |  | 10. IF UNDER 1 YEAR<br>Months Days Hours Min.   |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY   |   |
| 11. BIRTHPLACE (County & State, or foreign country)<br><b>Balto. Co. Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 13. FATHER'S NAME<br><b>David L. Kendig</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Laura Bieswanger</b>   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-30-9967</b>   |   |
| 17. INFORMANT<br><b>Mrs. Ethel V. VonGuten</b>  |  | Address<br><b>Reisterstown, Md.</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>422.1</b> IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b><br>DUE TO<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b)<br>(c) |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr</b>   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)<br><b>Acute Bronchitis</b>   |  |   | 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><b>none</b>   |  | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  |   |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>none</b> 19   | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)  |
| 21. I certify that (I) (the hospital) attended the deceased from <b>4-30-42</b> , 19__, to <b>1-31-67</b> , 19__, that (I) (we) last saw the deceased alive on <b>Jan. 25</b> , 19 <b>67</b> , and that death occurred at <b>8 A</b> .M, from causes and on the date stated above.                          |  |   |   |
| 22a. SIGNATURE<br><b>D. D. Caples</b>   |  | 22b. DATE SIGNED<br><b>2-1-67</b>   |   |
| 22c. PHYSICIAN'S NAME (Type)<br><b>D. D. Caples, M. D.</b>  |  | 22d. ADDRESS<br><b>6 Hanover Rd., Reisterstown, Md.</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>2/3/67</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>All Saints</b>   | 23d. LOCATION (City or Town) (County) (State)<br><b>Reisterstown, Md.</b>                         |
| 24. FUNERAL DIRECTOR<br><b>J. F. Eline &amp; Sons</b>   |  | 25a. REC'D BY REGISTRAR<br>DATE <b>FEB 3 1967</b>   |   |
| ADDRESS<br><b>Reisterstown, Md.</b>   |  | 25b. REGISTRAR'S SIGNATURE<br><b>J. Charles Judge</b>   |   |

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|------------|--|-----------------|--|
| NAME       |  | DATE            |  |
| ADDRESS    |  | CITY            |  |
| STATE      |  | ZIP             |  |
| TELEPHONE  |  | FAX             |  |
| E-MAIL     |  | WEB             |  |
| OCCUPATION |  | EDUCATION       |  |
| MARRIAGE   |  | CHILDREN        |  |
| PARENTS    |  | SIBLINGS        |  |
| RELIGION   |  | POLITICAL       |  |
| HOBBIES    |  | SPORTS          |  |
| TRAVEL     |  | VEHICLE         |  |
| MILITARY   |  | ACCOMPLISHMENTS |  |
| REFERENCES |  | REMARKS         |  |

FOR STATE  
HEALTH DEPT.

00477

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00480

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

|   |   |   |  |
|---|---|---|--|
| 1. PLACE OF DEATH<br>a. COUNTY<br><b>Baltimore</b><br>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 12</b><br>c. LENGTH OF STAY IN 1b<br><b>Baltimore 12</b><br>d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)<br><b>505 Regester Ave.</b>   |   | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)<br>a. STATE<br><b>Md.</b><br>b. COUNTY<br><b>Baltimore</b><br>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)<br><b>Baltimore 12</b><br>d. STREET ADDRESS<br><b>505 Regester Ave.</b><br>e. IS RESIDENCE ON A FARM?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 3. NAME OF DECEASED<br>(Type or print)<br><b>Salvatore Zito</b>   |   | 4. DATE OF DEATH<br>Month <b>1</b> Day <b>1</b> Year <b>1967</b>  |  |
| 5. SEX<br><b>M</b>  | 6. COLOR OR RACE<br><b>W</b>  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>5-18-1899</b><br>9. AGE (In years last birthday) yrs. <b>67</b> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Shop Owner</b>  |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Meat</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Italy</b>                              |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 13. FATHER'S NAME<br><b>Frank Zito</b>  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Rose Fertitta</b>  |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) (If yes give war or dates of service)<br><b>No</b>   |  |
| 16. SOCIAL SECURITY NO.<br><b>218-32-2799</b>   |   | 17. INFORMANT<br><b>Mrs. Minnie M. Zito</b><br>Address<br><b>Above</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>420.1</b><br>DUE TO <b>Coronary Occlusion</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Coronary Artery Disease</b><br>DUE TO <b>16 yrs</b><br>(c) <b>With Insults</b>  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b>   |  |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)<br><b>19. WAS AUTOPSY PERFORMED?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   |   |  |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/><br>CAUSE OF DEATH.  |   | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)   |  |
| 20c. TIME OF INJURY Month, Day, Year<br>Hour a.m. p.m. <b>19</b>  | 20d. INJURY OCCURRED<br>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  | 20f. (City or town) (County) (State)   |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |   |   |  |
| ACTUAL SIGNATURE<br><b>Charles F. O'Donnell</b><br>EXAMINER'S NAME (Type)<br><b>Dr. Charles F. O'Donnell</b>  |   | 22. DATE SIGNED<br><b>7/1/67</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/><br>Address (Street, city, town, or county)  |  |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>  | 23b. DATE THEREOF<br><b>1-5-67</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral</b>  | 23d. LOCATION (City or town) (County) (State)<br><b>Balto. Md.</b>                     |
| 24. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>4905 York Rd., Balto.</b>   |   | 25a. REC'D BY REGISTRAR<br><b>JAN 3 1967</b><br>25b. REGISTRAR'S SIGNATURE<br><b>Charles Judge</b>  |  |



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